STATE TITLE V BLOCK GRANT NARRATIVE
STATE: HI
APPLICATION YEAR: 2006

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

Copies of the Title V Assurances and Certifications are available by contacting:

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D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

Public input was obtained throughout the past year as part of routine staff presentations and participation in coalitions, advisory boards, conferences, professional and community meetings. Performance measure narratives were developed in consultation with input from collaborating agencies, community advocates, and families.

Copies of the Title V Block Grant Report and Application are routinely mailed to 25 agency partners, community representatives, and concerned individuals. Copies of the report are available directly from FHSD upon request by the public.

Generally, feedback on the report from past public meetings indicate that the document is too lengthy and cumbersome for use by the general public.

A link to the National Title V website may be placed on the newly redesigned Hawaii Department of Health website.

II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

GEOGRAPHY

Hawaii is situated almost in the center of the Pacific Ocean and is one of the most isolated yet populous places on Earth. The west coast of North America is 2,400 miles from Honolulu, roughly a 5 hour flight by air. Six time zones separate Hawaii from the eastern U.S. This means 9am (eastern standard time) in Washington, D.C. is 6 am in Los Angeles and 4 am in Hawaii.

The State is composed of seven populated islands located in four major counties: Hawaii, Maui, O‘ahu, and Kaua‘i (see attached Figure 1). The county is the lowest civil subdivision in the state. As a result, counties in Hawaii provide some services, such as fire and police protection, that in other states are performed by cities or towns. Counties also elect a mayor and council. Likewise, the state government is responsible for functions usually performed by counties or cities in other states. Hawaii is the only state, for example, with a single unified public school system.

Approximately 71% of the state population resides in the City and County of Honolulu on the island of O‘ahu, concentrated in the Honolulu metropolitan area. The neighbor island counties are Hawaii, Kaua‘i (includes Ni‘ihau) and Maui (includes Moloka‘i, Lana‘i, and Kaho‘olawe, the latter is unpopulated).

Only 10% of the state's total land area is classified as urban. The City and County of Honolulu is the most urbanized with a third of its land area and 96% of its population in urban communities. The majority of tertiary health care facilities, specialty and subspecialty services are located on O‘ahu. Consequently, neighbor island and rural O‘ahu residents often must travel to Honolulu for these services. Interisland passenger travel is entirely by air. Air flights are frequent, but comparatively expensive. Three of the ten most expensive airfares per mile in the U.S. are the connections between Honolulu and Maui, Honolulu and Kona (on Hawaii island), and Honolulu and Kaua‘i. This creates a financial barrier for neighbor island residents since round-trip airfare costs range from $140-$200.

Geographic access is further limited because public transportation is inadequate in all areas of the state except for the city of Honolulu. Residents in rural communities, especially on the neighbor islands, need an automobile in order to travel to major population centers where hospital, specialty, and subspecialty services are available. Because of the mountainous nature of the islands, road networks have been sparse and, in some places, limited to a single highway near the coast. Access to emergency care on neighbor islands often requires the use of helicopters or fixed-wing aircraft.

DEMOGRAPHICS

According the 2000 Census estimates, 1.2 million residents live in Hawaii up 9.3% from 1990. Maui County grew the most, up 27.6% to 128,094 residents; followed by Hawaii County with a 23.6% increase to 148,677; and Kaua‘i County with a 13.5% increase to 58,610. Honolulu registered the least growth by county at 4.8% with 876,156 people. Recent census estimates show neighbor island populations continue to grow faster than Honolulu.

Hawaii's population continues to grow steadily yet slowly at an average rate of 1.1% since 2002. That followed six years of growth below 1% from 1995 to 2001.

Hawaii's population, like the U.S. as a whole is aging. The median age of Hawaii residents increased from 32.6 to 36.2 over the last decade, higher than the national average of 35.3. The numbers of residents age 65 and over was up by 28% from 1990. But, the fastest growing age categories were in the 75-84 group (up 61%) and the 85 and over group (up 69%). The percentage of children age 0-5 years decreased by 6.1% from 1990. Decreases also occurred among young adults ages 20-24 (down 8.1%) and 25-34 (down 14.7%).

ETHNIC DIVERSITY

Unlike most of the United States, the ethnic composition of the state's population is very

heterogeneous and no single ethnic majority emerges. Caucasian, Japanese, Filipino, and Part-Hawaiian are the largest ethnic groups and their proportions differ by county. These four ethnic groups combined represent about 62% of the state's population according to the 2000 Census. Some 21.4% of the people in Hawaii indicate they are of two or more races.

Hawaii is considered a gateway to the U.S. for immigrants from Asia and the Pacific. According to U.S. Census and the Immigration and Naturalization Service, 16% of Hawaii's 1.2 million population is foreign-born, with just more than 61,000 immigrants legally admitted into the state between 1991 and 1998. Estimates of illegal immigrants in Hawaii range from 6,000 to 9,000.

Because of this ethnic diversity, there are a number of people who speak English as a second language. In 2003, approximately 7.8% (13,791) of the state's public elementary school children were enrolled in the Students with Limited English Proficiency Program, an increase from 44% since 1990. According to a 1999 report of the Governor's Council on Literacy, 154,000 or more than 20% of Hawaii's adults are functionally illiterate. The 2000 Census reports that 254,172 people in Hawaii speak a language in the home other than English.

ECONOMY

Hawaii is enjoying its strongest economy since the early 1990s, driven largely by active real estate, construction and tourism sectors. Hawaii's heavily dependent tourism economy was devastated by the 2001 terrorist attacks, the SARS (Severe Acute Respiratory Syndrome) outbreak in China, and initiation of the Iraq war.

Overall, Hawai'i's economy continues to hinge on visitor arrival growth. In 2004 the state hit a near record high of 6.9 million visitors. The state's unemployment rate of 2.7 percent reported for May 2005 is the lowest in 14 years and the lowest in the nation. Hawaii experienced job growth of 2.6% or 14,800 jobs in 2004. Real personal income rose 2.6% and has grown by 2.9% in the first quarter of 2005 (a 6.9% increase from a year earlier). Bankruptcy filings have also declined by 14%.

General fund revenues for the first 10 months of the state fiscal year are running 14.6% ahead of the previous year according to the state tax office in May 2005. General excise tax collections, the largest category of collections, were up 10%, the hotel room tax collections were up 7.9% and individual tax collections were up 15.8%. All of the economic indicators are pointing to a robust economy.

HIGH COST OF LIVING

Despite the generally positive outlook, a byproduct of economic growth is rising inflation that tempers gains made in personal earnings. Consumer prices rose 3.3 % last year mostly due to higher housing and energy prices. In May 2005, Hawaii surpassed California and has the highest gas prices in the U.S., according to Triple A. Hawai'i's average price remains just below a peak of $2.554 a gallon with slightly higher rates on the neighbor islands.

The major inflation driver is Hawaii's housing costs. In April 2005, the highest median single-family home prices were on Maui at $696,000; followed by Oahu at $545,000; Kauai at $540,000; and Hawaii island at $370,000. Even on the small rural island of Molokai with the highest unemployment rate, the average price home sold for $200,000.

The highest median condo prices in the state were on Kauai at $418,000, followed by Hawaii island at $397,000, Maui $330,000, and $243,000 on Oahu. With the median income for a family of four at roughly $71,320 (2003); the cost of home ownership is becoming out of reach for many families. According to 2004 Census estimates, Hawaii's homeownership rate was 58%, the third lowest in the U.S. in 2004.

Limited housing supply coupled with high demand is likely to keep housing prices rising and the market strong for at least the next one to two years. The buying boom has reduced the rental inventory and driven up rents, squeezing the most vulnerable sectors of society. Renters make up about 40% of the state's population, the third highest nationally. Low-income renters are hardest hit.

In a 2004 report, the National Low Income Housing Coalition called Hawaii the 7th least affordable state in the country. Residents need to make at least $17.60 an hour to afford a two-bedroom rental.

Moreover, the City of Honolulu in May 2005 stopped accepting applications for federal rental housing assistance with a waiting list of about 10,500 people. The state program on Oahu stopped placing names on its waiting list in 1999, yet there are still over 1,000 people waiting for vouchers. Homeless agencies fear a swelling population of people on the verge of homelessness. The University of Hawaii Center on the Family estimated that the state's homeless population was 13,000 last year, based on the number who used shelters or received outreach services.

POLITICAL CONTEXT

This has been the third legislative session under Governor Linda Lingle's administration. The major themes have been identifying solutions and funding for substance abuse prevention, treatment and prosecution, long term health care, and early childhood education. Increased revenues provide an opportunity to fund initiatives supported by the Governor. However, spending is still cautious, especially with union arbitrated salary increases for public employees at 5%, and teachers at 9.6%. Tobacco Settlement funds have been pulled back from the Healthy Start program with no replacement of the $5M with general fund revenues. The program will rely upon Medicaid generated funds and TANF Temporary Assistance for Needy Families) to assure that families are not without services. However, Healthy Start has been asked to review its program model to streamline cost and improve effectiveness. On a national level, the threat of the loss of the Preventive Health Block Grant will have implications on the State's ability to address injury prevention.

FELIX CONSENT DECREE

The Felix Consent Decree, issued in October 1994, has been the single major priority in the State's educational and health system for children, requiring enormous state appropriations and mobilization of staff to reach compliance with the terms of the decree to develop a system of care for children with special needs in accordance with Individuals with Disabilities Act (IDEA) and Section 504 of the Rehabilitation Act of 1973.

The Felix Consent Decree is the outcome of a 1993 lawsuit filed against the State in U.S. District Court on behalf of 7 children, their parents (guardians), and mental health advocates. The lawsuit alleged that qualified handicapped children were not receiving the educational and mental health service they needed and that the State was in violation of the law. The lawsuit was patterned after successful legal actions in the U.S., however, the Hawaii lawsuit involved all public schools in the state because Hawai'i has a statewide unified public school system.

To avoid a federal takeover of the state school system or be placed into receivership, the State entered into the Consent Decree and waived all rights to appeal and agreed to fully implement a statewide system of care by June 30, 2000. The State did not meet the deadline and was found to be in contempt by the federal court. The court set new compliance deadlines and identified a series of 56 benchmarks for the state to meet or face receivership of the educational system. In the effort, the Court granted the Directors of the State Education and Health Departments extraordinary powers to waive procurement laws, bypass state collective bargaining laws, and create new salaries levels for newly recruited special education teachers. The state was ordered to reach compliance without any consideration for costs.

Since 1994, the State has spent almost $1.5 billion on Felix related programs. The DOE's expenditures for Felix programs grew from $77.5 million in 1994 to $179.8 million in 2001 an increase of 132%. The DOH's general fund expenditures for Felix grew from $48 million in 1995 to $148.2 million in 2001, an increase of 209%. All this occurred at a time when Hawaii's economy was undergoing a crippling downturn. These costs do not include federal funds expended by DOH and expenditures by other agencies including the Attorney General's Office and DHS.

Felix Programs in FHSD, CSHNB Early Intervention Section (EIS) and MCHB Healthy Start, focus on Part C of IDEA, early intervention services. DOH serves as the lead agency in Hawaii for Part C

services. Hawaii has the most comprehensive definition in the nation of children to be served under Part C of IDEA. This definition provides eligibility for infants and toddlers with developmental delay in one or more areas, those with biological risk factors, and those at environmental risk. Hawaii is one of the few states to provide full entitlement under Part C to infants and toddlers with environmental risk factors. The legislature appropriated funds to assure the statewide implementation of Healthy Start Early Identification and Home Visitation Program. The legislature has appropriated funds for EIS to meet the federal, state, and court mandates for services. Increases in referrals and early identification of children with mental health needs (autism spectrum disorder) and intense level of interventions (individual behavioral supports) contribute the growing EIS costs.

In June of 2004 the State of Hawai`i was declared to be incompliance with the Felix Consent Decree. However, court oversight will continue until December 2004, to document that the improvements made to the health and educational system for special education is sustainable.
In June 2005, the State of Hawai`i was found to be fully compliant with Felix Consent Decree and released from court oversight.

The noteworthy health bills that passed in the 2005 legislative session include:

Tobacco permit
Requires retailers selling tobacco products to obtain a $20 permit from the state Department of Taxation by March 2007. Sets criminal penalties and forfeiture for retailers who sell tobacco without a permit. Will assist in monitoring of tobacco retailers, ensure accurate collection of tobacco taxes.

Early childhood education
Provides $50,000 for a task force to study how to improve quality and access to preschool.

School lunch prices
Authorized the state Department of Education to adjust the price of school lunch to cover up to half the total cost of operating the program.

Minimum Wage
Raises the minimum wage from $6.25 in 2006 and $7.25 in 2007.

Excise tax surcharge
Allows counties to add a surcharge of up to 0.5% on the state's 4% general excise tax to pay for transit projects. Counties would have until the end of the year to pass a tax, which could not be collected until January 2007. The tax would expire after 15 years. Honolulu is the only county actively considering a tax increase, which would be used to help pay for a rail project.

Pseudoephedrine
Sets a limit of 3 packages or 9 grams on any single purchase of products with the ingredient, which can be used to make "ice." Requires stores to keep the products behind the counter, in plain view of clerks, or within the scope of security cameras.

Caregiver consent
Gives a minor's caregiver the right to consent to healthcare services for the minor; establishes requirement for caregiver consent affidavits.

Developmental disabilities, mental retardation
Makes an emergency appropriation to the state Department of Health for home and community based providers of services for those with developmental disabilities or mental retardation.

Early Intervention Services
Makes an emergency appropriation for additional funds from the Early Intervention Special Fund to the Family Health Services Division for services for infants and children up to age 3.
S.C.R. 13/45/168:

Mandates the Department of Health and the Department of Human Services continue their work on an interagency Task Force to increase coordination between the Hawaii Healthy Start child abuse prevention program and Child Welfare Services.

H.C.R. 227:
Budget Proviso HB 100:
Requires the DOH to convene a Healthy Start (HS) advisory board to address various programmatic development issues within HS to increase overall program effectiveness and clarify the definition of successful outcomes for families served in HS.

Access to specialty care
Resolution requesting the State Health Planning and Development Agency to identify and evaluate the barriers to community-based access to specialty care and to make recommendations to improve access to specialty care on the neighbor islands and in rural Oahu.

Mental health
Expands the definition of "serious mental illness" that health insurance plans must offer coverage to include delusional disorder, major depression, obsessive compulsive disorder and dissociative disorder.

Graduated licenses
Creates a provisional driver's license between the permit and full license stages for those under 18; puts restrictions on the hours and number of passengers for those with provisional licenses; sunsets provisional licenses in 5 years.

Affordable housing
Ominbus bill gives greater flexibility for developers seeking rental housing loans and grants; establishes a general excise tax exemption for developers who set aside half their units as affordable; gives priority over rental housing funds to those developers who provide units for those families making 80% or less of median family income.

WELFARE REFORM
In Hawaii the Department of Human Services (DHS) administers the Temporary Assistance to Needy Families (TANF) program. The state responded to the 1996 federal Welfare Reform Initiative by creating a TANF waiver referred to as PONO (Pursuit of New Opportunities). One of the objectives of PONO is to cut welfare dependency and to increase self-sufficiency. When the program was implemented in 1996, the welfare population was approximately 20,825 cases. The current population as of April 2005 is 8,236 cases. Of the current number, approximately 3,732 clients are expected to be able to enter the work force. All "able-bodied" TANF recipients experienced a 20% reduction in their cash benefits in the first year of the PONO program. Those individuals who are currently employed while in the program (about 1,737 individuals) have been able to earn back this 20% reduction, as well as an additional amount of allowed income, and are therefore in improved economic shape. An additional group of over 900 recipients are obtaining job experience with volunteer placements. However, they do not have supplemental income to offset the decrease in cash assistance and have experienced a degree of economic hardship.

The full impact of welfare reform has not yet been felt for low-income populations. The First-to-Work (FTW) Program serving parents receiving TANF has been active and services approximately 2,450 cases per month and an unduplicated number of 7,951 per year.

Since July 1999 DHS began enforcing full family sanctions for non-compliance with federal work requirements. In December 2001 Hawaii began to terminate benefits to welfare families that exceeded the five year lifetime limit for financial assistance. Between December 2001 and June 2002, over 3,000 families lost eligibility due to the five year time limit. A disproportionate number of these families live on the island of Hawaii.

To provide greater support for Hawaii's working poor, the 2001 Legislature voted to increase the minimum wage by $1 to $6.25 by 2003 after staying the same for nine years. The increase places Hawaii eleventh in the nation for highest minimum wage. The state minimum wage is well above the federal rate of $5.15.

The 2005 Legislature passed a law to raise the minimum to $7.25 by January 2007. If the bill is not vetoed by the Governor, the increase would place Hawaii third in the nation for highest minimum wage behind Washington and Oregon.

HEALTH INSURANCE

Historically, Hawaii has had a large proportion of its population covered by some form of health insurance. In the 1980s, Hawaii's uninsured population was estimated at 5 percent, and the state was credited as having the lowest uninsured rate in the U.S. This is a legacy from traditional Hawaiian society; the subsequent plantation era where medical care was provided for workers, and the rise of strong labor unions.

Prepaid Health Care Act

The generally accepted principle of broad or universal access to health care is reflected in the passage of the Hawaii Prepaid Health Care Act of 1974. The Act requires employers to provide a group health plan for employees working at least 20 hours a week for at least four straight weeks and earn at least $542 a month. The law also mandates a minimum set of benefits that must be provided.

Hawaii is the only State with such a requirement and was successful in obtaining a waiver from the federal Employee Retirement Income and Security Act (ERISA), which prohibits state regulation of self-insured employers. The law does not require employers to cover dependents, so families may be omitted from coverage. Recent large increases in insurance premiums over the past few years have raised concerns about the Act and its impact on businesses in Hawaii.

UNINSURED

By the late 1990s, the uninsured rate slowly increased to 8 percent and currently 9.9%. Other state health surveys report lower rates ranging from 5% to the Census high of 9.9%, approximately 60,000 to 120,000 persons without insurance. Using Census estimates, Hawaii ranks sixth in the nation for lowest uninsured, tied with New Hampshire and Vermont.

Despite the protections of the Prepaid Health Care Act, a large number of uninsured in Hawaii are working full-time and should have employer-based health care coverage. Research conducted by the Hawaii Uninsured Project (HUP) indicate about 37% of the state's uninsured adults work more than 20 hours per week.

It is generally believed that there is very high employer compliance with the law, however, there are government employees who are exempt from the law or working in family businesses. Anecdotally, researchers understand that there are also some young adults waiving health insurance benefits in exchange for higher wages. And there is an underground economy where employees accept jobs without benefits for needed income.

As a result of the HUP findings, the state Department of Labor and Industrial Relations (DLIR) began sending out investigators to ensure businesses are complying with the Hawai'i Prepaid Health Care Act. During 2005, DLIR will be investigating small and large firms chosen randomly by computer. Oahu County investigators will get a list of 60 companies per month to audit, Maui County will get 25, while Hawaii and Kauai counties will get 24 and 12, respectively.

INSURANCE MARKET

To address rising health care costs, the Hawaii health insurance market has shifted toward managed care in both the private and public sectors. In 2002, 81% of insured Hawaii residents were covered under some form of managed care program, an increase of 31% since 1992.

Hawaii's inflation rate for medical care increased substantially to 8.3% in 2002, up from 1997's low of 1.1%, and twice as high compared to the national rate of 4.7%. This is in part due to the dramatic rise of retail prescription drug costs in Hawaii by 12.5% between 2001 and 2002.

The financing of health care in Hawaii's private sector is dominated by two health plans: the Hawaii Medical Service Association (HMSA, the Blue Cross and Blue Shield plan) which was founded in 1935, and Kaiser which began operating in Hawaii in 1958. In 2002 HMSA insured 32% of the Hawaii market, while Kaiser covered 14%.

Although there was a significant commercial insurance presence at one time, it has dwindled due to the State's isolation, limited consumer market and aggressive competition from HMSA and Kaiser. To address Hawaii's shrinking health insurance market and rising health costs, legislation was passed in 2002 to regulate health insurance plans to assure insurance rate increases are not excessive, yet sufficient to keep insurance companies viable in the long term. Hawaii was one of the last states in the U.S. to pass such legislation.

In 2002, government funded insurance represented 34.5% of residents in Hawaii: 8% Medicare, 14% for Medicaid/QUEST, and 8% covered by TRICARE that provides health care to military families and retirees.

MEDICAID
The Hawaii QUEST demonstration project is a Medicaid waiver project administered by the Department of Human Services Med-QUEST Division which began in August 1994. QUEST is an acronym that stands for: Quality Care, ensuring Universal Access, encouraging Efficient Utilization, Stabilizing Costs, and Transforming the way health care is provided. QUEST has 2 basic objectives: to expand medical coverage to include populations previously ineligible for Medicaid and to contain costs by shifting fee-for-service to a managed care delivery system. Savings realized from such a shift would be used to expand coverage.

Economic changes and liberal eligibility criteria have led to a tightening of the eligibility within the QUEST program. In 1996 QUEST reduced the 300% Federal Poverty Level requirement to 100% FPL and placed an enrollment cap on the program of 125,000 members, from the high of 160,000 in January 1996. Certain groups are not subject to the cap and can enroll at anytime: pregnant women, children under 19 years of age, foster children and children in subsidized adoptions under age 21, adults whose incomes do not exceed the TANF payment limit, and people who apply within 45 days of losing their employer sponsored coverage due to loss of employment.

As of December 2004 QUEST enrollment was 157,810. Fee for service coverage (for Aged, Blind, and Disabled) was 40,200 for a total of 198,010.

Hawaii implemented the State Children's Health Insurance Program (SCHIP) as an expansion of Medicaid and QUEST. As a result, children under 19 whose family incomes do not exceed 200% FPL are eligible under QUEST. There is no assets test. Children who are legal immigrants arriving after August 1996, refugees and those born in the Marshall Islands and Federated States of Micronesia and Palau were eligible under both SCHIP and QUEST effective July 1, 2000 under a state funded immigrant program.

QUEST allows participants to select medical plans from the 3 current participating providers: HMSA, Kaiser and AlohaCare. As of December 2004 HMSA covered 54.5% of QUEST enrolless, Kaiser 12.9% and AlohaCare 31.4% (another 1.1% are under QUEST FFS). Not all providers are available on each island. Dental coverage is a full dental benefit for children but limited to emergency and palliative services for adults and was moved from managed care to fee-for-service in October 2001.

Initially, QUEST was to incorporate all existing Medicaid recipients, including the aged, blind, and disabled (ABD) population through Phase II of the project in 1997. The State currently has an application in with the Centers for Medicare and Medicaid Services (CMS) to move the ABD

population to managed care. The anticipated date for enrollment into managed care plans is July 1, 2007.

Hawaii's waiver program expires on 30 June 2005. An application for renewal and expansion of the current Medicaid QUEST waiver program was submitted with extensive input from the community and providers. All current QUEST eligibility groups would continue and, depending on cost projections and available resources DHS plans to expand services by:

* Extending children's coverage under the State Children's Health Insurance Program (CHIP) from the current family income level of 200% of the federal poverty level (FPL) to at least 225% FPL.

* Eliminating a requirement that children must be enrolled in QUEST to continue in QUEST-Net (a program developed mainly for people who no longer qualify for QUEST with income levels up to 300% FPL). This ensures that all children from families with incomes at or below 300% FPL have access to the full QUEST benefit package with no cost to families up to at least 225% FPL and with a reasonable premium for families with income up to 300% FPL.

* Providing QUEST coverage for all children in the state's child welfare system. The few who are not otherwise eligible will be covered by a state-only benefit. These children will receive additional services through the QUEST plans, including direct access to a specially trained health care provider to identify and handle child abuse and a complete examination and assessment within an established number of days of entering the system.

* Piloting a Health Insurance Flexibility and Accountability (HIFA) program for employed individuals leaving Temporary Assistance for Needy Families Program (TANF). Parents will be offered COBRA-like premium assistance for an additional year after their mandatory Medicaid coverage ends.

The goal is to increase access to high quality health care, reduce the number of uninsured children, and preserve Hawaii's generous federal matching funds at sustainable levels.

Efforts to achieve universal coverage continue through other projects. The DOH has partnered with the HMSA Foundation to address the issue of the uninsured. Hawaii's Uninsured Project conducted a conference this past year to identify the issues surrounding the uninsured and to develop appropriate strategies.

In January 2004 Hawaii was awarded $3.2 million in RWJ Foundation funds for a three year project to implement universal health care coverage. Work continued this year in partnership with the University of Hawaii, Social Science Research Institute and Hawaii Institute of Public Affairs to define the uninsured, frame their issues, explore solutions with stakeholders, and conduct economic modeling of the various options.

The Hawaii Uninsured Project published On Common Ground in 2002 which outlined the issues around the uninsured: who are they and what are their issues. In January 2005, HUP published Pathways to Coverage which outlined strategies endorsed by a broad cross-section of stakeholders to expand coverage further. The Department of Human Services has shortened its application form and has implemented passive renewal which has resulted in increased enrollment. DHS has also extended QUEST coverage to pregnant immigrant women.

STATE CHILD HEALTH INSURANCE PROGRAM
The State Children's Health Insurance Program (SCHIP), enacted in August, 1997, provided new incentives for states to extend public health insurance coverage to low-income uninsured children. The federal government offered states a higher federal match and greater flexibility to design their programs than they enjoyed under Medicaid. Hawaii uses Tobacco Settlement revenues to fund the State match for SCHIP.

The Department of Human Services (DHS) is the lead agency in Hawaii for the State Child Health

Insurance Program (SCHIP). Hawaii's SCHIP program, a Medicaid expansion, began on July 1, 2000, and covers all children under 19 years of age with family incomes up to 200% of the Federal Poverty Level (FPL) for Hawaii. There is no waiting period for SCHIP eligibility. As of December 2004, 13,719 children were enrolled in SCHIP.

Effective July 1, 2000, legal immigrants, refugees, and those born in the Marshall Islands, Federated States of Micronesia and Palau were eligible for QUEST-like health coverage under a state-funded immigrant children's program which has the same eligibility requirements as QUEST. As of December 2004, 2,855 immigrant children were enrolled.

STATE DEPARTMENT OF HEALTH: CURRENT PRIORITIES & INITIATIVES
The 2005 Department of Health Annual Report identifies four initiatives for continued focus:

1. Develop sustainable solutions that ensure the provision of quality of care for the elderly;
2. Improve Hawaii's mental health system
3. Advocate for the adoption of healthy lifestyles to reduce the incidence and morbidity of chronic disease;
4. Public Health emergency preparedness.

The promotion of the ten essential public health functions is still a cornerstone priority of the Department. Family Health Services Division programs and activities are in alignment with three of the six stated goals of the Department of Health:

1. Promote and encourage healthy and safe behaviors.
2. Assure equitable, accessible health and support services.
3. Attain a culture of organizational excellence that provides effective public health programs and leadership for the State of Hawaii.

B. AGENCY CAPACITY

Public Health in Hawaii, including the Title V program, continues to transition from direct services to the core public health functions aimed at improving the health of the entire population consistent with national health objectives. The landmark 1988 Institute of Medicine Report, The Future of Public Health, characterized these core functions as assessment, policy development and assurance.

As funding for direct health care services shifts away from public health agencies to the medical community and other providers, the role of the Title V program changes. In the context of this changing health care system, the Hawaii Title V agency works to promote and develop an environment that supports the optimal health of all women of child bearing age, infants, children, adolescents and families. Hawaii's MCH programs work to ensure statewide infrastructure building functions such as data collection, needs assessment, surveillance, planning and evaluation, systems and policy development, monitoring, provision of training, and technical assistance to assure quality of care.

The challenge for public health is to assure that the health of the community is improved and protected given the complex changes occurring in health care financing and delivery.

In Hawaii the Title V agency is the Family Health Services Division (FHSD) in the State Department of Health . FHSD is organized into the 3 Branches: Children with Special Health Needs Branch (CSHNB), Maternal and Child Health Branch (MCHB), and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). The mission of FHSD is "to assure the availability of and access to preventive and protective health services for individuals and families by providing leadership in collaboration with communities and public-private partners."

The Division goals are:
1. Pregnancy/conception shall occur by choice and under circumstances of lowest risk.

2. Every pregnant woman will utilize appropriate services and engage in healthy behaviors to optimize outcomes.

3. All infants, children and adolescents, including those with special health care needs, will receive appropriate services to optimize health, growth and development.

4. All families will have a safe and nurturing environment, free of violence and will engage in behaviors to promote optimum health.

5. Access to quality health care shall be assured through the development of a comprehensive, coordinated community-based, family-centered, culturally competent system of care.

6. FHSD shall have the necessary infrastructure to support the implementation of the core public health functions.

PROGRAM INITIATIVES
The 2005 Session of the Hawaii State Legislature proved to be tumultuous for FHSD early intervention programs. While the Legislature wanted to ensure adequate funding for both the Healthy Start and Early Intervention programs, they did not reauthorize use of $5 million in Tobacco Settlement funds for this purpose. Early Intervention Special Fund dollars of $2 million, generated from Medicaid reimbursements for EI services, were earmarked for Healthy Start for a net decline of $3 million from current levels. Mandated services under IDEA Part C to infants and children up to three years of age will receive at least $2.5 million from the EI special fund under the authorization for State FY06. It is anticipated that an emergency appropriation for additional funds for EI mandated services will be needed to meet the needs for FY06. The Healthy Start program was under intense scrutiny and anticipates substantial retooling over the next two years.

FHSD has worked vigorously to gather timely, reliable data regarding the health of our state's families to assure that needs are met by effective communication to the state legislature and by obtaining additional federal and private resources to supplement available state funds. Statistics show Hawaii residents enjoy relatively good health compared to national standards; however, significant disparities exist between geographic regions within the state and between different ethnic groups. FHSD has accepted responsibility for identifying and addressing these disparities as they relate to the health of our women, children, and families.

The current administration has placed a priority on data and the tracking of health outcomes. Tobacco Settlement funds have been used to fund the Hawaii Outcomes Institute in conjunction with the School of Medicine to increase the research and epidemiological capacity of the state. Similarly, FHSD has tried to enhance program efficiency and effectiveness through several initiatives.

FHSD is enhancing data capacity through increased partnerships with the DOH Office of Health Status Monitoring; investing federal State Systems Development Initiative, Title V, and Primary Care office resources into the Hawaii Health Survey, the Pregnancy Risk Assessment Survey, and other health surveillance tools; and maximizing use of a Centers for Disease Control-assigned Title V funded MCH epidemiologist.

The Division has contracted with a private firm to develop its Early Intervention Data Management System. Parts of the system are operating to improve clients tracking, program reporting and billing. Data linkage initiatives between newborn screening programs and vital statistics are completed. Data is routinely linked. New initiatives include linkage with WIC and birth certificates. Discussions are underway with Medicaid to explore procedures for data linkage with birth certificates.

WIC's statewide automated information system provides important program data for this large at-risk population. Linkage with vital statistics, Medicaid and other datasets is being explored and the WIC dataset is scheduled to be placed in the electronic data warehouse in late 2005. Data linkage will help strengthen collaboration between WIC and other programs in childhood immunizations, breastfeeding, oral health and assuring access to health and social services for low-income children and mothers. In July 2005, WIC services on the island of Molokai will be transferred from State staff via contract to a Native Hawaiian Health Care System provider.

FHSD is working to improve collaboration both within the Division, within DOH, and across State departments to assure efficient use of ever limited funding resources.

MCH Branch is administering surplus TANF funding to contract with agencies to promote teen pregnancy prevention efforts. Funds have been used to hire a administrator to manage program contracts.

The Division has strengthened its capacity to perform the ten essential public health functions by encouraging staff to participate in data analysis and management training sponsored by the Hawaii Outcomes Institute. In addition four staff have graduated from the University of Hawaii Maternal and Child Health Certificate program, another three staff are currently enrolled in the program.

PROGRAM CAPACITY
The three branches of Family Health Services Division (FHSD) target all three major Title V populations: infants and mothers, children and youth, and children with special health care needs.

The following is a brief description of the basic role of the Director's Office, the three branches, the District Health Offices on the neighbor islands, and FHSD planning, evaluation, data analysis capabilities.

DIVISION CHIEF'S OFFICE
The Office of the Division Chief is responsible for overall management, administration, and direction of the Division. Included in this are activities of program planning, development, evaluation, coordination, and research. The Director's Office oversees coordination for the Office of Primary Care, Title V, the State Systems Development Initiative, and the Data Utilization and Enhancement (DUE) grants. The attached chart shows the staff and functions under the Director. The seven positions funded with federal Title V funds are identified on the chart in addition to the Branch Chief for CSHN.

CHILDREN WITH SPECIAL HEALTH NEEDS BRANCH (CSHNB)
The Children with Special Health Needs Branch promotes integrated systems of care that assure that children and youth with special health care needs will reach optimal health, growth, and development. CSHNB has 185 FTE time employees, of which 19 are Title V funded. Programs include Early Intervention, Preschool Developmental Screening, Newborn Hearing Screening, Newborn Metabolic Screening, Children with Special Health Needs, Genetics, and Birth Defects Programs. CSHNB works to improve access for CSHCN to a coordinated system of family-centered health care services and improve their outcomes, through systems development, assessment, assurance, education, collaborative partnerships, and supporting families to meet their health and developmental needs. Direct and enabling services are provided as mandated by law, as a safety net for CSHCN/families who have no other services, and to improve access of CSHCN to needed health care services.

MATERNAL AND CHILD HEALTH BRANCH (MCHB)
The Maternal and Child Health Branch, comprised of 69 FTEs, works to promote and protect the health and well-being of mothers, infants, children and their families in the context of their communities. Eighteen of these positions are Title V funded, 20 state-funded and 31 funded by other federal sources. The branch is divided into four program sections: Perinatal Support Services, Children and Youth Health Services, Family Planning Services and Family Support Services. MCHB contracts for many direct, enabling and population based services through a collaborative network of non-profit and private providers. The Branch program staff concentrates primarily on core public

health services like assurance activities through contract monitoring; systems development through mobilizing community partnerships and coalitions; monitoring of health status, service delivery and utilization; and developing strategies to improve health status. The Branch continues to support a broad mandate with a limited infrastructure.

SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, & CHILDREN (WIC)
The Special Supplemental Nutrition Program for Women, Infants & Children (WIC) is a federally funded short-term intervention program providing nutritional counseling and food assistance for low-income pregnant and post-partum women and children up to age 5. During F FY 2003 & 2004, Hawaii WIC served an average of 32,788 and 33,221 individuals a month, respectively, drawing closer its goal of providing nutritional services to an estimated 41,000 eligible persons statewide. Approximately 50% of the caseload is children age 1-5 years, 25% are women and 25% are infants. With 115.5 FTEs located throughout the state, the program is designed to help establish good nutrition and health behaviors through nutrition education, breastfeeding promotion, a monthly food prescription allotment and access to maternal, prenatal and pediatric health-care services. WIC services are provided through purchase-of-service (POS) and state-run agencies. WIC contracts with six Community Health Centers, one Native Hawaiian Health Care Center and one hospital to provide services, resulting in greater integrated health service delivery. Along with income eligibility (185% of poverty level), all participants must be considered nutritionally "at-risk."

DISTRICT HEALTH OFFICES
Administration of all Department of Health programs on the neighbor islands are provided by the three District Health Offices (DHO) located on the islands of Kaua‘i, Maui and Hawaii and follow political county jurisdictions. Kaua‘i DHO is also responsible for the island of Ni‘ihau. Maui DHO is responsible for the islands of Lana‘i and Moloka‘i. Each DHO has a Registered Nurse with public health experience, who functions as the FHSD Coordinator responsible for the administration of FHSD programs: CSHN (including Early Intervention Services), WIC, Maternal and Child health. They also coordinate FHSD programs in family planning, perinatal services and primary care. Each office may also administer grants specifically designed to target the needs of their rural island communities.

Neighbor Island FHSD Coordinators are uniquely positioned at the community level to ensure coordinated service delivery to consumers. Based on community needs, the Coordinators are responsible for providing all levels of service delivery from Direct to Infrastructure Building Services. Neighbor Island Coordinators are also closely involved with building the system of service delivery for State Department of Education Special Education programs under IDEA. This is not the case for the Division offices on O‘ahu. On O‘ahu, programs for school age children under IDEA are coordinated largely between the Department of Health's Child and Adolescent Mental Health Division and the State Department of Education.

Each Neighbor Island FHSD office is organized somewhat differently. The FHSD Coordinators often oversee many other District Health Office functions and responsibilities for other health areas.

HAWAII COUNTY
The FHSD Neighbor Island Coordinator functions on the Island of Hawaii are handled by a Nurse Manager for Special Services. Maylyn Tallett provides DHO administrative supervision and support for Title V programs, which include Children With Special Health Needs (2 Social Workers, half-time Clerk Typist) and Early Intervention Section (8 Social Workers, 1 Quality Assurance Specialist, 1 Occupational Therapist Program Manager, 1 Occupational Therapist, 1 Physical Therapist, 1 Speech Language Therapist, 1 Special Education Teacher, 2 Paramedical Assistants, 1 Data Clerk and half-time Clerk Typist) and a Clerk Steno. The supervision of the Malama A Ho'opili Pono Project and WIC are managed by individual program supervisors.

Other related MCH duties include facilitating the Hawaii & Tri-County Dental Task Force meetings and Community Health Centers -- Oral Health Issues meetings. The Nurse Manager represents the DHO at the following meetings, the Hawaii Island Tobacco Free Partnership Coalition, Keiki Injury Prevention Coalition, Big Island Good Beginnings Alliance, East Hawaii Friends of Foster Families,

Hawaii County Behavioral Health, Primary Care Roundtable and the Breast and Cervical Cancer Control Programs. Additional responsibilities include the management of special projects, such as providing support to the Hawaii Island Anti-Bully Coalition to provide awareness & education to the community about bullying behavior utilizing the Domestic Violence Prevention Special Fund. Also, the Nurse Manager is currently assisting the Community Health Centers to create a sustainable network of agencies to provide dental services to children throughout the entire island. Furthermore, ongoing collaboration with the Department of Education to form a network with the Early Intervention staff and private agencies to provide assistance to children eligible for IDEA services, has been positive and allowed for improved transitions.

MAUI TRI-ISLE COUNTY
The FHSD programs in Maui Tri-Isle County are supervised by a registered nurse, Jeny R. Bissell, who is responsible for the administrative supervision of all FHSD programs and employees, which includes WIC (2 nutritionists, 6 paramedical assistants, 2 clerks, 1 clerk-typist), Early Intervention (5 social workers), CSHN (1 social worker), MCH (1 registered nurse), and a clerk steno. Substantial time is devoted toward building a coordinated system of services, in collaboration with the Department of Education and Part C Agencies for children eligible for IDEA services. Additional duties include special projects related to Title V, FHSD, and/or the Maui District Health Office such as the Injury Prevention Project and Primary Violence Prevention Project.

Duties and supervision responsibilities for the position have been changed slightly. While each program will be directed by the Branch supervisor on program related issues, the FHSD Coordinator will work closely with the community to assure effectiveness of Title V programs. She will also identify unmet needs of the Title V target population and, through partnerships with other agencies, design special programs and projects to address these issues. Currently, examples of such special programs for Maui include, oral health, lead, mercury, tobacco, alcohol and substance abuse. Additional duties include special projects related to Title V, FHSD, and/or the Maui District Health Office such as the Injury Prevention Project, Primary Violence Prevention Project and Tobacco Prevention and Outreach Project.

Other duties for the FHSD Coordinator include participation in the Maui State and County Agencies Servicing Children, Maui Part C-IDEA Collaboration Agencies, Maui Children Welfare Services (CWS) Citizen Review Panel, Early Head Start and Head Start Health Advisory Council, Sequenced Transition to Education in the Public Schools (STEPS) Interagency Team, Maui Children Justice Center Committee, Title IV B Maui Regional Planning Group, Primary Care Roundtable and Maui Homeless Alliance. Other duties include serving as an alternative representative to the Maui Maternal and Child Health Coordinator in the Pediatric and Women Board Committee, Maui Tobacco Free Partnership, Children Welfare Advisory Council and Coalition to End Abuse. Additional duties include serving as an alternative representative to the Maui District Health Officer in the Tri-Isle Dental Alliance and MEO BEST Advisory Council.

KAUAI COUNTY
The Kauai FHSD programs are supervised by a registered nurse Cashmere Lopez. She provides the administrative supervision and support to the Title V programs which include Children With Special Health Needs Program (1 social worker), WIC (1 nutritionist, 2 PMA, 1 clerk-typist, 1 clerk), Maternal & Child Health (1 nurse coordinator), and Early Intervention Section (3 social workers). The Program Manager is also responsible for several Title V service contracts and grant funded initiatives on the island that includes Malama Kauai Project, Malama Smoking Cessation Programs. Malama (which means to "protect" or "to care for" in Hawaiian) programs address the needs of high risk pregnant women. Other related MCH duties include leadership roles on the Primary Health Care Consortium, (to address health care access and elimination of health disparities), Kauai Dental Health Task Force, Medical Home Initiative, Kauai Drug Task Force, Kauai Community Children's Council (partnership for IDEA children's services), Mokihana Project (partnership with DOE and Child & Adolescent Mental Health for coordinated school-based mental health services), Good Beginnings Kauai,(integrating child care and early preschool into the broader community system of services and supports for young children and their families), Tobacco Free Kauai Coalition, Get Fit Kauai Coalition (promoting physical

activities and good nutrition), and the Kauai Keiki Injury Prevention Coalition.

CONTRACTED SERVICES
The Hawaii health delivery system depends on public-private partnerships for the delivery of all services, including MCH services. The vast majority of community prevention, primary care and specialty services are provided by private health care providers and community-based non-profit organizations. FHSD contracts with a wide range of these providers (both public and private), using a competitive bid process for most of its community-based services. Nearly 200 purchase of service contracts, memorandum of agreements and fee for service contracts were executed in state fiscal year 2004 totaling nearly $51 million to deliver direct, enabling, population based and infrastructure building services to the MCH population.

All vendors with FHSD contracts to provide direct and enabling services must report on uniform performance measures that assure the quality of care. Contracts are monitored by FHSD program staff by area of expertise. Most contracts are for the provision of direct and enabling services. A smaller portion of the contracts include technical assistance with data capacity, epidemiological analysis and research, evaluation services, community development, and auditing services.

C. ORGANIZATIONAL STRUCTURE

The Department of Health (DOH) is one of the major administrative agencies of state government with the Director of Health reporting directly to the Governor (see attached chart). DOH works with the Governor-appointed Board of Health to set state public health policies. The DOH is divided into 3 major administrations (see attached chart), one of which is the Health Resources Administration (HRA). There are 6 major divisions within HRA including the Family Health Services Division (FHSD), which is responsible for the administration of all Title V funding. The Children with Special Health Needs Branch is part of FHSD.

The 2001 election of Governor Lingle has resulted in the appointed of all new state department directors and deputy directors. Dr. Chiyome Leinaala Fukino, M.D. is the current Director of Health, with Dr. Linda Rosen (formerly the FHSD Medical Director) as the Health Resources Deputy; Susan Jackson is the Administrative Deputy; Michelle Hill is Deputy for Behavioral Health, and Laurence K. Lau is the Environmental Health Deputy.

D. OTHER MCH CAPACITY

There are approximately 418 full-time equivalent employees in FHSD. This includes temporary and permanent positions. Of the total, roughly 45 FTEs are funded using federal Title V monies (7 at Division level, 18.5 at CSHN Branch and 19.5 at MCH Branch). Most of the Title V funded positions have been created to build the Division/Branch level infrastructure capacity.

Approximately 105 FTEs of the Division employees are based in the three district health offices on the neighbor islands: 67 FTE on Hawaii island, 12 on Kauai and 26 on Maui.

The Division has 1 epidemiologist position located at the MCH Branch. Currently, a CDC-assigned epidemiologist works at the Division level. Plans are underway to establish another epidemiologist position at the Division level. The Division also has 7 research statisticians at Division and at the MCH and CSHN branches; 5 planners at Division and MCHB; and 11 data processing staff at Division and at WIC and CSHNB.

Due to anticipated State budget deficits the program has been under a periodic hiring freeze despite pending vacant positions. All federally funded positions have been approved for hire by the Governor.

Most State general funded positions which are approved for filling are those which are under court mandates, i.e. Early Intervention Services and Healthy Start. The Division is aggressive in its attempts to seek private foundation and federal grants to continue to advance the goals and objectives of Title V.

Brief biographical information on the FHSD senior level management staff is presented.

LORETTA FUDDY, FHSD Division Chief
Ms. Loretta Fuddy holds degrees in sociology, social work, and public health from the University of Hawaii. She is currently the Chief of Family Health Services Division, serving in this position for four years. Her area of expertise for twenty-five years has been in the promotion of health and social services for women and children through the State of Hawaii. Ms. Fuddy has made numerous national and international professional presentations regarding the subject of maternal and child health prevention programs. She serves as clinical faculty for the University of Hawaii Department of Public Health and School of Social Work. She serves as a health consultant to Hawaii's efforts to reform and improve its child protective services. She is also a board member for the March of Dimes, Chapter of the Pacific, the Hawaii Children's Trust Fund, and the Good Beginning Alliance. She is the current President of the Hawaii Public Health Association, immediate Past President of the Association of State and Territorial Public Health Social Workers, and is a member of AMCP's Work Force Development committee.

DR. PATRICIA HEU, Children with Special Health Needs Branch Chief
Dr. Patricia Heu, MD, MPH, is a pediatrician and has served as the Children with Special Health Needs Branch Chief for eight years. She graduated from the University of Hawaii (UH) with a degree in Biology and received her M.D. from the University of California San Francisco, in 1976. She pursued pediatric residency with the University of Hawaii/School of Medicine/Department of Pediatrics at Kapiolani Medical Center for Women and Children and later received her Masters in Public Health from UH specializing in Maternal and Child Health. Her prior experience includes Medical Consultant to the MCH and School Health Services Branches, and clinic pediatrician and Clinical Director for the Waimanalo Children and Youth Project (serving a rural Hawaiian community on the island of Oahu). She serves on numerous advisory bodies and committees concerning CSHCN. She provides medical consultation for CSHNB programs, as needed.

ALTHEA MOMI KAMAU, Maternal and Child Health Branch Chief
Althea Momi Kamau, RN, BSN, MPH, has 38 years of experience in maternal and child health and public health nursing. She has served as Maternal and Child Health Branch Chief since 2000 after serving as MCHB Supervisor for Children Health Services for 4 years. Her experience in the Department of Health includes Public Health Nursing Assistant Branch Chief, Support Services Supervisor in the School Health Branch, EPSDT Program Head in MCHB, and 16 years as a public health nurse. She also worked for 7 years in the rural Hawaiian community of Waianae, Oahu overseeing school based health and employment services to adolescents.

LINDA CHOCK, WIC Services Branch Chief
Linda Chock, MPH, RD has served as WIC Director and Chief, WIC Services Branch since 2002. She previously served as the WIC Clinic Operations Section Chief since 1997. Her years of experience includes clinical and administrative dietetic work at both private and public hospitals, public health nutrition education, and nutrition program planning and management at federal, state and regional levels of government.

CHARLENE GASPAR, Nurse Consultant
Ms Gaspar, RN, MPH has over 35 years of experience in maternal and child health and public health. Her field experience in community based public health nursing took place in rural areas of the state and most of her career has been in administering public health programs and grants. She has been the director of the Rural O‘ahu Family Planning Project and the Hilo Maternity and Infant Care Project on the island of Hawaii. As nurse consultant for the Title V agency in Hawaii for over 15 years, her role has evolved from primarily providing nursing consultation to planning and administration. She

currently coordinates the federal Primary Care Office and State Systems Development Initiative grants, and the development of the Title V Annual Report and Application.

DR. LOUISE IWAISHI, Medical Director
Dr. Iwaishi is currently Medical Director for the Family Health Services Division. She had been in private pediatric practice in a multispecialty group for 10 years before joining the faculty of the University of Hawaii John A. Burns School of Medicine(JABSOM) in 1991. As assistant professor in the Department of Pediatrics, her focus has been residency training in primary care and developmental pediatrics. She oversees two training grants, the Hawaii MCH LEND program (interdisciplinary training) and the Hawaii Dyson Initiative(community pediatrics). She studied Zoology at Pomona College in California, received her M.D. from the University of Hawaii, JABSOM and completed her pediatric residency training at Kapiolani Medical Center for Women and Children's pediatric integrated residency program. Dr. Iwaishi is immediate past president of the American Academy of Pediatrics-Hawaii Chapter where she advocated for child health issues related to Title V and AAP initiatives (e.g. Family Voices Early Intervention and Transition projects, the Medical Home primary care provider, Early Periodic Screening Diagnosis andTreatment (EPSDT) services, Medicaid child health financing, primary prevention community coalitions).

PARENT INVOLVEMENT IN CHILDREN WITH SPECIAL NEEDS PROGRAMS
The Children with Special Needs programs involve families in various ways, including councils, task forces, and advisory committees; development and review of client education materials; participation in presentations and panels; participation in conferences and training sessions; interview panels for staff positions; advocacy for legislation; and input on proposed changes for policies and procedures. Parents are compensated or assisted in various ways including stipend or payment on an hourly basis as appropriate; airline coupons and ground transportation for Neighbor Island families; and child care during activities. Family participants are of diverse ethnic and cultural backgrounds. For more information on family participation initiatives see the narrative on National Performance Measure 02.

E. STATE AGENCY COORDINATION

DEPARTMENT OF HEALTH
Within the Department of Health, Title V works with the District Health Offices and various Divisions/programs including Community Health, Developmental Disabilities, Dental Health, Child and Adolescent Mental Health, Alcohol and Drug Abuse, Communicable Disease, Emergency Medical Services, Office of Health Status Monitoring, the State Health Planning Agency as well as the Environmental Health Administration.

DEPARTMENT OF EDUCATION
Hawaii has a single unified public school system serving kindergarten to grade 12. Over 182,000 students are enrolled in public schools, roughly 84% of all students enrolled in educational institutions.

The Title V program participates in the DOE-DOH Comprehensive School Health Program (CSHP) infrastructure development collaborative funded by the Centers of Disease Control and Prevention to establish interagency leadership to support the implementation and sustainability of the CSHP.

Title V also provides assistance to the DOE Peer Education Program located in 26 high and middle schools to help students develop healthy lifestyles addressing risk behavior including sex assault, violence, teen pregnancy, teen suicide, substance abuse, and STD/AIDS. Title V also organized and participates in an interagency committee to administer the major school health surveys.

The CSHNB/Early Intervention Section (EIS) works collaboratively with the DOE in several areas:

a) The State Improvement Grant is a collaborative effort of the DOE, University of Hawaii (UH) Center on Disability Studies, DOH/EIS, and DOE/Parent Training Information Center to improve systems providing early identification, educational, early intervention, and transitional services to children with

disabilities. Through a Memorandum of Agreement (MOA) with DOE, EIS will be funded to identify and address barriers to early identification of infants/toddlers with disabilities, improve the process of transitioning eligible children and their families from the Early Intervention Program to DOE preschool special programs or other options, and assist in the process and outcome evaluation plan.

b) EIS and DOE developed transition materials and regularly provide joint training to early interventionists, DOE staff, families, and other community members.

c) To support the transition of young children with autism, the DOE is utilizing space at an early intervention program for a DOE classroom and regularly includes children under age 3 with autism in classroom activities.

d) EIS and DOE are continuing a pilot project to support the continuation of early intervention services as an Extended Year Services option for eligible children who turn age 3 during the summer months and are eligible for DOE preschool special education services.

e) EIS collaborates with the DOE and DOH/Child and Adolescent Mental Health Division (CAMHD) by implementing internal reviews for children from birth to age 3. EIS also participates in an Interagency Quality Assurance Taskforce that includes DOE, CAMHD, DHS, and Hawaii Families as Allies.

WIC serves with various representatives from the DOE on a variety of committees. In certain cases, WIC works closely with the DOE nutritionists to coordinate the amount of formula provided by DOE versus WIC.

DEPARTMENT OF HUMAN SERVICES
DHS houses programs critical to the health and welfare of the state MCH population including Medicaid, Temporary Assistance to Needy Families (TANF), Food Stamps, Child Welfare Services, Disability Determination, Vocational Rehabilitation, Child Care Services, and Youth Services Programs.

DHS provides funding to FHSD for early intervention services provided by the EIS, Healthy Start, and Public Health Nursing Branch, through a carved-out, non-risk, capitated plan offered by DOH for QUEST-eligible infants and toddlers who are developmentally delayed or biologically/environmentally at risk.

DHS provides funding support for EIS, for the following:
a) Inclusion Project provides tuition support for infants/toddlers with developmental delays to participate in child care or community-based program.
b) Keiki Care Project provides technical assistance and training to community preschool staff serving children ages 3-5 with behavioral challenges and their families.

Healthy Child Care Hawaii receives funding from DHS for recruiting, training, and linking health consultants to child care programs; training pediatric residents in early childhood/child care, and promoting the Caring for Our Children national health and safety performance standards, medical home, and health insurance.

MCH Branch is a member of the DHS EPSDT Advisory committee and partners with DHS to conduct assessment and planning to assure prevention services that focus on family strengthening are available to those in need. A recent agreement between the DHS Medicaid Agency and DOH resulted in a coordinated statewide response to children with elevated lead levels.

MCHB collaboration with DHS programs includes child welfare/safety issues through projects like the Blueprint for Change, Title IVB Advisory groups, the Community Based Child Abuse Prevention Program (CBCAP) and the Child Death Review.
DHS agreed to use surplus TANF funding for teen pregnancy prevention efforts. Title V helped facilitate discussions among key stakeholders to identify effective strategies to utilize the funding.

DHS has supported the implementation of teen pregnancy prevention training programs with TANF funds including an administator position in MCHB. Title V partners with DHS and the DOE to oversee training projects with the University of Hawaii; Kapiolani Medical Center for Women and Children Teen Intervention Program; and the John A. Burns School of Medicine, Department of Public Health Sciences and Epidemiology for evaluation of these programs.

Families that qualify for DHS services (Food Stamps, TANF and Medicaid) are automatically income eligible for WIC. Thus, the agencies work closely to ensure clients receive information and assistance to apply for available services. DHS allows WIC limited computer access to the DHS enrollment system to check on adjunctive income eligibility for WIC applicants.

DHS Disability Determination Branch refers children under age 16 years with disabilities who are medically eligible for Supplemental Security Income (SSI) to the Children with Special Health Needs Program (CSHNP). CSHNP provides outreach, assessment, information/referral, and/or service coordination as needed, regarding the SSI beneficiary's medical, education, and social needs. These are "rehabilitation" services required by Title V for individuals under age 16 years receiving benefits under Title XVI of the Social Security Act.

The State Primary Care Office (PCO) is located within the Title V agency and works in partnership with public, private and voluntary organizations that are committed to the medically underserved in the State including, but not limited to, the Hawaii Primary Care Association, the Hawaii Area Health Education Center, the Native Hawaiian Health organizations, the Native Hawaiian Scholarship Program, the Hawaii Dental Association, neighbor island District Health Offices, and other state agencies.

EXAMPLES OF PUBLIC AND PRIVATE COLLABORATION

The Hawaii Early Intervention Coordinating Council (HEICC) advises the Director of Health on issues related to the planning, implementation, evaluation, and monitoring of the statewide system of early intervention services, and assists the DOH in achieving the full participation, coordination, and cooperation of all appropriate public agencies in the state. Members are appointed by the Governor and include: parents of children with special needs, early intervention providers, legislators, pediatrician, and representatives from the DOE, DHS, University of Hawaii (UH), and health insurance. Membership of the HEICC will be expanded to meet the new requirements in IDEA 2004.

The Creating Opportunities for All Children (COACH) Project is an EIS project funded by the DOH/Child and Adolescent Mental Health Division through a MOA. This project provides technical assistance and consultation to community preschool staff serving children ages 3-5 who were in early intervention services, are not DOE eligible, but continue to have social/emotional/behavioral challenges.

Tracking, Integration and Research for Early Screening, Assessment, and Intervention (EASI) project is a collaborative effort of CSHNB with the UH Center for Disabilities for data integration and research studies related to early hearing detection and intervention. EIS provides space and use of equipment to UH Center for Disabilities Studies staff.

The Special Education Advisory Council (SEAC) is an advisory committee to the Superintendent of Education for policies on any issues in the education of students with disabilities. Appointed membership, as specified in the Individuals with Disabilities Education Act, includes representative of consumer advocate groups, parents, individuals with disabilities, regular and special education personnel, DOH, DHS, and UH. The Council has been actively working with the DOE to enhance the work environment and improve the recruitment and retention of qualified special education teachers and other support staff. The Council is working with the DOE to implement a Comprehensive Student Support System (CSSS) and school-based mental health services, training initiatives, and addressing the educational needs of special education students within the Justice System. EIS is represented on

SEAC.

The Newborn Metabolic Screening Advisory Committee consists of consumers and professionals (physicians, laboratory personnel, nurses from various birthing facilities, medical insurance plan representatives, parents, and other DOH representatives) from the private and public sectors. The committee's purposes are to provide support, guidance, and feedback to DOH about newborn screening; disseminate information about newborn screening to colleagues and the community; monitor accountability and quality of the newborn screening program; and discuss ideas and issues relevant to newborn screening.

The Hawaii Birth Defects Program (HBDP) Advisory Committee is composed of representatives from the community, medical, university, and public and private sectors. Members offer scientific guidance and input into the program and have expertise in the areas of children with special health needs, service delivery, epidemiology, research, family health, fetal diagnosis, genetics, health information management, maternal and child health, neonatology, nursing, pediatrics, perinatology, public health, and fetal/pediatric ultrasonography.

The State Genetics Advisory Committee consists of representatives from public health, health care organizations, consumers, laboratories, insurance, policy makers, and other interested organizations such as the March of Dimes. The Committee advises the DOH about genetics activities and helps disseminate information about these activities.

The Healthy Child Care Hawaii Advisory Team includes the American Academy of Pediatrics (AAP)-Hawaii Chapter, UH/Department of Pediatrics-Dyson Initiative, DOH, DHS, DOE, parents of young children, pediatrician health consultants, early childhood centers, Head Start, Hawaii Association for the Education of Young Children, Hawaii Medical Home Implementation Project, Dyson Initiative, Hawaii Covering Kids, Good Beginnings Alliance, and People Attentive to Children.

The Early Hearing Detection and Intervention Advisory Committee advises the Newborn Hearing Screening Program, the Baby Hearing Evaluation and Access to Resources and Services (HEARS) Project, and the Tracking, Integration and Research for Early Screening, Assessment, and Intervention (EASI) Project. The committee includes: parents, AAP-Hawaii Chapter, Center for Disabilities Studies, early intervention programs, Hawaii Academy of Audiology, Hawaii Speech Language and Hearing Association, Hawaii Center for the Deaf and Blind, UH/Department of Pediatrics, hospital newborn hearing screening program, Gallaudet University regional center, Hawaii Kids Count, and pediatric audiologists.

Hawaii Community Genetics is a partnership of DOH/CSHNB Genetics Program, Kapiolani Medical Center for Women and Children, Queen's Medical Center, and University of Hawai`i John A. Burns School of Medicine to develop clinical genetics and metabolic services in Hawaii. HCG has successfully recruited a full-time geneticist for clinical services. Clinical genetics services are expanding with the addition of a hemoglobinopathy clinic, neighbor island clinics, and telemedicine visits.

The core team of CSHNB, Family Voices, UH/School of Medicine/Department of Pediatrics, and American Academy of Pediatrics-Hawaii Chapter, with other key state/community partners, continues to work closely together in various projects toward achieving the six core outcomes for CSHCN. Current collaborative projects are Medical Home Implementation Project, Hilopa`a Project--Integrated Services for Children & Youth with Special Health Care Needs, and a transition & family leadership project funded by the Champions for Progress Center (MCHB cooperative agreement with Utah State University that provides leadership support for state Title V/CSHCN programs in systems building).

CSHNB is a member of the State Council on Developmental Disabilities. Act 175 of the 2001 Legislature required that the Council's membership include a representative of Title V of the Social Security Act. The Council's responsibilities include: development of the state plan which guides the development and delivery of all services for individuals with developmental disabilities, coordination of

departments and private agencies, evaluation, and advocacy.

The Early Childhood Comprehensive System (ECCS) Strategic Management Team consists of public and private representatives charged with improving the system of early childhood services in the state. With a grant from the federal MCH Bureau, an assessment of the service system was completed and a strategic plan developed. The SMT provides leadership for the plan's implementation. Members include Departments of Education, Health, and Human Services, Good Beginnings Alliance, Hawaii Association for the Education of Young Children, Hawaii Medical Home Initiative, Hawaiian family service organizations, Housing and Urban Development, Kamehameha Schools, AAP, and parents.

Hawaii State Child Death Review Council is a voluntary public-private partnership formulated in 1996 through the leadership of Title V to establish a comprehensive, statewide, multidisciplinary child death review system to reduce preventable child deaths from birth to age 18. In 1997, state statute authorized the DOH to conduct child death reviews. The Child Death Review Council, with broad representation from the private and public sector, oversees the development and implementation of CDR.

The Hawaii Children's Trust Fund (HCTF) was established by statute in 1993 to support family strengthening programs aimed at preventing child abuse and neglect and promoting healthy child development. HCTF is comprised of a coalition of parents, public and private agency personnel with an Advisory Committee and Board. The endowment fund consists of three streams of funding: federal funding from the Community-Based Child Abuse Prevention program (CBCAP), private donor contributions, and monies received from a tax check-off program.

Keiki Injury Prevention Coalition (KIPC) is an organization of over 60 private and public partners in the community, including neighbor island chapters. Title V staff participate in statewide activities to address issues related to childhood injury prevention. The Safe Sleep Committee, under the leadership of Title V staff, develops community-based prevention strategies. Title V is also active on the Suicide Prevention Steering Committee. KIPC supports networking with agencies and community organizations to effect legislation, policy, and educational measures to reduce injuries.

Hawaii Immunization Coalition is a statewide, community-based coalition of public and private agencies, which ensures that all of Hawaii's residents are appropriately immunized against vaccine-preventable diseases. Activities include sharing information and resources, educational materials, policy development, and training for health professionals/organizations on current immunization information. Immunization practices to address access issues and barriers for at-risk populations and data information systems continue to be priorities.

The Task Force on Pediatric Obesity at Kapiolani Medical Center for Women and Children is an organization initiated by pediatricians to address the increase rate of childhood obesity in Hawaii. The membership has expanded to include representatives from public and private agencies who are partnering to identify data, strategies and resources in the community to prevent and treat childhood obesity.

The Hawaii Perinatal Consortium (HPC) is a statewide leaders' forum organized to share information and data, define the unique needs of our state, and promote strategies to improve perinatal health. The HPC utilizes members' expertise to advance changes in health policy and public awareness through interaction with government, corporate, and community decision makers. HPC is an advisory group for policy development to interface with related coalitions and groups involved in perinatal health, provides a bridge for newly emerging issues, and assists organizations in data collection and presentation.

Healthy Mothers, Healthy Babies (HMHB) Coalition of Hawaii is a nonprofit agency and part of a national network of organizations and individuals committed to improving maternal, child and family health through collaborative efforts in public education, advocacy, and collaboration. HMHB

distributes educational materials for pregnant women and provides leadership for advocacy efforts by convening quarterly meetings of perinatal providers, disseminating regular news updates, and advocating for the adoption of important statutes and policies affecting perinatal health.

The Hawaii Teen Pregnancy, Prevention and Parenting Council (HTPPC) is a network of public and private agencies and individuals (collaborators) dedicated to improving public information and interagency communication around issues of teen pregnancy prevention and parenting. The HTPPC activities include statewide and community based educational outreach.

The Substance Abuse Free Environment (S.A.F.E.) Council is a statewide organization of community and agency representatives who meet to address issues concerning substance using pregnant women. The Council provides leadership and direction for the service delivery needs of the substance using pregnant women. The Council has testified at the legislature, co-sponsored training sessions for professionals, and worked closely with the DOH Alcohol and Drug Abuse Division and the DHS Child Welfare Division to coordinate advocacy efforts and program planning.

The Fetal Alcohol Spectrum Disorders (FASD) Task Force was established in March 2005 to prevent the adverse outcomes from prenatal exposure to alcohol and develop comprehensive systems of care for those affected by FASD. Members include representatives from state agencies, UH School of Medicine, state chapters of ACOG and AAP, Center for Disabilities Studies, the primary health care centers, private providers, and families.

The USDA-FNS Hawaii Council is comprised of the U.S. Department of Agriculture (USDA) and USDA-funded Nutrition and Nutrition Assistance State agencies of the DOH Executive Office on Aging, Department of Labor & Industrial Relations, DHS Food Stamp Program, University of Hawaii's Cooperative Extension Service, DOE, and WIC Program. A memorandum of agreement supports collaboration between agencies to share goals and activities, implement culturally appropriate nutrition education materials, and share resources.

The Hawaii Head Start-State Collaboration Project Advisory Council's mission is to assist the State of Hawaii in improving life outcomes and opportunities for Head Start-eligible families. The DOE, DHS, and the WIC Program are represented on the council. The seven priority areas of collaboration are: health care, welfare, child care, education, national service activities, family literacy services, and activities relating to children with disabilities.

The University of Hawaii Maternal Child Health Program, Department of Public Health, in the School of Medicine was awarded a federal grant to develop the MCH Certificate Program to provide training in data analysis and data-based program management. The program has attracted many Title V and community agency staff and plays a vital role in building public health capacity in the state. MCH faculty provides important technical and research assistance to the MCH community.

F. HEALTH SYSTEMS CAPACITY INDICATORS

F. Health Systems Capacity Indicators

The Health Systems Capacity Indicators (HSCI) measure the capacity of system of care for the MCH population and the data capacity of the Title V agency to effectively monitor the health status of the MCH population. The data is reported on Forms 17-19. Data was collected for most of the Health Status Indicator measures (HSI) with a few exceptions.

HSCI #01 THE RATE OF CHILDREN HOSPITALIZED FOR ASTHMA (10,000 CHILDREN LESS THAN 5 YEARS OF AGE).
Data for this measure comes from the Hawaii Health Information Corporation (HHIC) a private, not-for-profit corporation established in 1994 to collect inpatient discharge records from Hawaii's 22 acute care hospitals for each year since 1993. The rate excludes newborns, pregnancy-related admissions

and patients admitted through a transfer from another facility. The denominators are from 2004 U.S. Census.

The rate of pediatric hospitalizations for asthma per 10,000 children continues to decline, although the differences are not significant.

The Hawaii State Asthma Control Program (HSACP) is the lead for asthma issues in the Department of Health (DOH). HSACP is currently engaged in the construction of Hawaii's Comprehensive State Asthma Surveillance System (CSASS) that will be designed to measure and track the asthma burden through 4 key indicators: 1) asthma prevalence, 2) asthma severity, 3) asthma management, and 4) asthma cost. In the meantime, HSACP released a report in 2004 documenting the current data on asthma prevalence in the state.

Approximately, 9.7% or 28,600 children age 0-17 years currently have asthma according to the 2002 Hawaii Behavioral Risk Factor Surveillance System (BRFSS). The survey also shows that about 14.1% or 41,600 children living in Hawaii reported having asthma at some point in their lifetime. While children in Hawaii county have a higher prevalence rate (12.2%) than other counties, the finding is not statistically significant.

HSCI #02 THE PERCENT OF MEDICAID ENROLLEES WHOSE AGE IS LESS THAN ONE YEAR WHO RECEIVED AT LEAST ONE INITIAL PERIODIC SCREEN.
Data for this measure comes from the Med-QUEST Division (MQD), the Medicaid agency in the State Department of Human Services (DHS), HCFA-416 Annual EPSDT Participation report Historically, Hawaii has had a high percentage of Medicaid enrollees under the age of one year receiving at least one initial EPSDT periodic screen.

HSCI #03 THE PERCENT OF STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) ENROLLEES WHOSE AGE IS LESS THAN ONE YEAR WHO RECEIVED AT LEAST ONE PERIODIC SCREEN.
Since SCHIP is a Medicaid expansion program in Hawaii, separate service utilization data is not available for SCHIP enrollees at this time. Thus, data for FY 2001-2004 are estimates. It is unclear whether the Medicaid agency will be able to provide this information in the future. Title V will continue to request this information. Information for FY 2004 was not available to complete an estimate for the indicator, thus data for 2003 was used.

HSCI #04 THE PERCENT OF WOMEN (15 THROUGH 44) WITH A LIVE BIRTH DURING THE REPORTING YEAR WHOSE OBSERVED TO EXPECTED PRENATAL VISITS ARE GREATER THAN OR EQUAL TO 80% ON THE KOTELCHUCK INDEX.
FY 2004 is provisional since the final birth record file is not complete. The data indicates the adequacy of prenatal care visits appear to be declining slightly over the past 5 years. The rates for 2003 and 2004 (provisional data) appear to be significantly different from the 2000-02 rates. The reason for this is unclear at this time, but will be explored.

HSCI #05 COMPARISON OF HEALTH SYSTEM CAPACITY INDICATORS FOR MEDICAID, NON-MEDICAID, AND ALL MCH POPULATIONS IN THE STATE.
Medicaid linkage with vital statistics has not been achieved at this time, thus the Medicaid/Non-Medicaid comparison data is not complete. Linkage discussions with the Medicaid agency will continue through work funded by the federal MCH Bureau State Systems Development Initiative (SSDI) grant. The Medicaid Director has agreed to consider a pilot project to link Medicaid data with birth certificate files.

HSCI #06 THE PERCENT OF POVERTY LEVEL FOR ELIGIBILITY IN THE STATE'S MEDICAID AND SCHIP PROGRAMS FOR INFANTS (0 TO1), CHILDREN, AND PREGNANT WOMEN.
Eligibility requirements for Medicaid and SCHIP remain the same.

HSCI #07 THE PERCENT OF EPSDT ELIGIBLE CHILDREN 6 THROUGH 9 YEARS WHO HAVE RECEIVED ANY DENTAL SERVICES DURING THE YEAR.
Preliminary data from Medicaid was provided. Title V will continue to request the information and update this measure when data becomes available.

HSCI #08 THE PERCENT OF STATE SSI BENEFICIARIES LESS THAN 16 YEARS OLD RECEIVING REHABILITATIVE SERVICES FROM THE STATE CHILDREN WITH SPECIAL HEALTH CARE NEEDS PROGRAM.
Data on children under age 16 receiving SSI payments was provided by the CSHNB/Children with Special Health Needs Program, in which social workers and other health professionals provide outreach services to medically eligible SSI applicants referred by Disability Determination Services, and to SSI beneficiaries referred by other community resources. December 2004 data on children under age 16 receiving SSI payments for Hawaii was provided by the Social Security Administration, in a table sent to CSHNB by the Healthy and Ready to Work National Center.

HSCI #9A THE ABILITY OF STATES TO ASSURE THAT THE MCH PROGRAM AND TITLE V AGENCY HAVE ACCESS TO POLICY AND PROGRAM RELEVANT INFORMATION AND DATA.

ANNUAL DATA LINKAGES
Since 2001, the State Systems Development Intiative (SSDI) grant staff has worked to facilitate data linkage with birth certificate files. In 2002, a Data Linkage Project Team, composed of administrators from the Department of Health (DOH) Office of Health Status Monitoring (OHSM), the Department of Human Services MedQUEST Division (MQD), WIC and the Hawaii Health Information Corporation was established. The Team has been providing guidance to the SSDI data linkage initiative.

For several years, annual data linkage for infant birth and infant death certificates has occurred for infants one year old and younger at OHSM, the vital statistics office. The Title V program has had access to the linked database for a number of years.

In order to facilitate annual linkage of birth certificate files with other datasets, a State Attorney General's (AG) opinion was requested on linking birth certificate files with newborn screening records. In 2003, the AG's opinion established the legality of linking these databases and indicated that linkage could occur either at OHSM or at the Children with Special Health Needs Branch (CSHNB), the agency responsible for state newborn screening programs. To ensure confidentiality of vital records, OHSM requested that linkage occur at OHSM and CSHNB agreed. To assure that all newborns are screened in the state, CSHNB asked that vital statistics information be used to identify parents whose infants have not been screened. The AG's opinion stated that the data cannot be used to identify and contact infant's families, and that contacting families can only be done through changing the vital statistics statute. The state vital statistics law says that birth certificate data can be used for research purposes only without identifiable information.

In 2004, CSHNB and OHSM began to link birth certificate files and newborn screening files on an annual basis. The Newborn Hearing Screening Program and Newborn Metabolic Screening Program databases are linked at CSHNB, and the linked newborn screening database is provided to OHSM. This CSHNB database is linked with the birth certificate files at OHSM, then sent to CSHNB along with selected demographic variables for analysis. This annual linkage has been very successful with a 2003 linkage rate of 99.5% and a 2004 linkage rate of 99.8%.

With the receipt of the AG's opinion, the WIC program agreed to a pilot project using birth certificate files and selected WIC data elements. The pilot project was recently initiated and as of July 2005, a 91% match rate has been achieved for clients born in 2004. The WIC program and OHSM will work toward increasing this rate and the possibility of annual linkage. As a result of the WIC linkage, OHSM has added an identifier field to the linked WIC file and the linked newborn screening files so that these files can all be linked. This presents tremendous potential for further analysis and will require increased epidemiology assistance.

Discussions with the Department of Human Services Med-QUEST Division have taken place sporadically since 2002 regarding linkage of birth certificate and Medicaid files. During that period, the Med-QUEST Division administrator (Medicaid Director) left her position and the program has had two acting administrators, with the new acting administrator coming on board in 2005. As a result of discussions with the new Med-QUEST administrator and OHSM, a tentative agreement has been made to conduct a pilot project to match birth certificate files and selected Medicaid data elements at OHSM. The pilot project is subject to confirmation from the Centers for Medicare and Medicaid Services (CMS) that Medicaid data can be shared and a memorandum of agreement approved by the State Attorney General's office.

REGISTRIES AND SURVEYS

The Hawaii Health Information Corporation (HHIC) is a private non-profit organization that maintains a database with more than 1,000,000 patient discharge records collected from Hawaii's 22 hospitals for each year since 1993. Since this database exists, hospital surveys are not necessary. The reports generated by HHIC are usually for its 22 constituent hospitals and may be proprietary. However, other aggregated reports are available to the Title V agency. For a fee, HHIC can generate special analyses and reports for programmatic and policy purposes.

Hawaii is one of a limited number of states that maintains a population-based active surveillance system for birth defects through the Hawaii Birth Defects Program (HBDP). HBDP is funded through a contract administered by the CSHNB and regular program reports are generated. However, the Title V program does not have direct access to the HBDP data files as state law prohibits sharing of this confidential database.

The MCH Branch within the Title V agency conducts the ongoing Pregnancy Risk Assessment Monitoring System (PRAMS) and has direct access to this database. Calendar year 2000 was the first full year of data obtained from the survey. The PRAMS database has been and will continue to be analyzed for program planning and policy development.

HSCI #9B THE ABILITY OF STATES TO DETERMINE THE PERCENT OF ADOLESCENTS GRADES 9 THROUGH 12 WHO REPORT USING TOBACCO PRODUCTS IN THE PAST MONTH.
Since 1989, the Youth Risk Behavior Survey (YRBS) has been administered every two years in the Department of Education in collaboration with the University of Hawaii and the Centers for Disease Control and Prevention. The University of Hawaii, Curriculum Research and Development Group has been contracted to administer the YRBS in Hawaii from 1993 to the present and is the repository for the electronic dataset. Reports are generated that include the percent of adolescents grades 9 through 12 who report using tobacco products in the past month. The Title V Program had initially taken the lead in organizing and facilitating an Adolescent Survey Committee (ACS) to assure that the YRBS is implemented and funded. The ASC has focused in recent years on coordinating the administration of all the school health surveys (i.e. tobacco, substance use, and health curriculum) to alleviate the burden on the schools. The ACS is focusing on designing an effective coordinated process to administer the various school health surveys. The process utilized in 2003 did not produce the response rates needed to generate weighted data and is being evaluated and modified for the 2005 school year.

HSCI #9C THE ABILITY OF STATES TO DETERMINE THE PERCENT OF CHILDREN WHO ARE OBESE OR OVERWEIGHT.
YRBS data on obese or overweight adolescents is available (see HSCI 9B) and is monitored as a Title V state performance measure. The Hawaii WIC program tracks data on weight for clients from birth to 5 years. Title V has direct access to this data. The WIC child weight data is submitted to the national Pediatric Nutrition Surveillance System dataset at the Centers for Disease Control and Prevention (CDC). Title V does not have direct access to the PedNSS dataset, but can access summary reports provided by CDC.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

The Government Performance and Results Act (GPRA - Public Law 103-62) requires that each Federal agency establish performance measures that can be reported as part of the budgetary process that links funding decisions with performance and related outcome measures to see if there were improved outcomes for target populations.

In compliance with GPRA, the following progress report on the Title V Maternal and Child Health National and State Performance Measures is presented annually. The measures are reviewed by the Types of Service as shown in the pyramid in Figure 1. Specific program activities are described and categorized by the four service levels found in the MCH "pyramid" - direct health care, enabling, population-based, and infrastructure building services. Because of the flexibility inherent in the Block Grant, the program activities or the role that Title V plays in the implementation of each performance measure may vary among States (i.e., monitor, advocate, provide, supplement, assure).

The goal for the state MCH agency is to focus on building the essential infrastructure services that assure an effective system of care exists to maintain the health of the MCH population.

Figure 2 presents schematically the Title V Block Grant Performance Measurement System designed to build state-level infrastructure capacity. The system begins with the assessment of needs, identification of priorities, program and resource allocation, tracking of performance measures, and culminates in improved outcomes for the Title V population.

The program activities, as measured by the National and State Performance measures, should positively impact the Outcome measures for the Title V population. While improvement in outcome measures is the long-term goal, more immediate success may be realized by a positive impact on the performance measures which are considered shorter term, intermediate, and precursors for the outcome measures. This is particularly important since there may be other significant factors outside of Title V programs that affect the outcome measures.

The performance measure system ensures fiscal accountability in three ways:

1) by measuring the progress towards successful achievement of each individual performance measure;

2) by having budgeted and expended dollars spread over all four of the recognized MCH services: direct health care, enabling services, population-based services, and infrastructure building services; and

3) by having a positive impact on the outcome measures.

Based on a five year needs assessment, the State Title V agency identifies up to 10 priority health issues of unique concern to the State that may not normally be addressed by the national performance measures. A state performance measure is identified for each state health priority. The State may revise its priorities based on the results of on-going needs assessment or the mandated 5-year needs assessment. Form 11 lists the current 10 state measures with data for the reporting year. Like the national performance measures, narrative reports are also presented for these state measures.

The completion of the five-year needs assessment in this year's FY 2006 application resulted in the deletion of several measures and addition of new measures. Detail sheets for the new state performance measures are in Form 16.

In FY 2004 report, Hawaii met or exceeded its Annual Performance Objectives for 5 of the 12 National Performance Measures (the 5 Children with Special Needs measures that rely on the national CSHN

survey were excluded and PM 13 that had no data to report this year) and met or exceeded its Annual Performance Objectives for 5 of the 9 State Performance Measures (no 2004 data for SPM 03). Hawaii met or exceeded 6.3 Healthy People 2010 objectives for measures with numerical targets and contributed to meeting 5 HP 2010 objectives without numerical targets.

Once submitted, the Block Grant application is subject to a standardized review process. The focus of the Review is on the progress being made by each State to meet its performance goals and identify technical assistance that may be needed in order for the State to move towards achieving these goals.

B. STATE PRIORITIES

Ten priority issues were identified through the 2000 Maternal and Child Health five year needs assessment. These priorities are the programmatic focus areas for FHSD working in partnership with other agencies/programs through 2010. Each priority is described in relationship to National and State performance measures used to track them. For a discussion of the capacity and resource capability of the State Title V program to address these priorities see the respective discussion under the performance measures.

1. REDUCE ADULT (PARENTS, PREGNANT WOMEN) & ADOLESCENT SUBSTANCE ABUSE.
The performance measures related to this priority are:
SPM 3 The percent of women who report use of alcohol, tobacco, and other drugs during pregnancy.
SPM 5 The percent of teenagers in grades 9 to 12 attending public schools who report smoking tobacco within the last 30 days.

2. REDUCE FAMILY VIOLENCE AND CHILD MALTREATMENT.
The performance measures related to this priority are:
NP 16 The rate (per 100,000) of suicide deaths among youths 15-19.
SPM 7 Rate of confirmed child abuse/neglect reports per 1,000 for children aged 0-5 years.
SPM 8 Percent of teenagers in grades 9 to 12 attending public schools who report being involved in a physical fight within the last 12 months.

3. REDUCE THE RATE OF UNINTENDED PREGNANCY
The performance measures related to this priority are:
NPM 8 the rate of birth (per 1,000) for teenagers ages 15-17 years.
SPM 11 The percent of pregnancies (live births, fetal deaths, abortions) that are unintended.

4. IMPROVE THE DENTAL HEALTH OF CHILDREN
The performance measure related to this priority is:
NPM 9 The percent of 3rd grade children who have received protective sealants on at least one permanent molar tooth.

5. REDUCE OVERWEIGHT AND OBESITY IN CHILDREN
The performance measure related to this priority is:
SPM 13 The percent of teenagers in grades 9 to 12 attending public schools that are overweight.

6. IMPROVE ACCESS TO HEALTH CARE
The performance measures related to this priority are:
NPM 1 The percent of newborns who are screened and confirmed with conditions mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) and who receive appropriate follow up and as defined by their State.
NPM 3 The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.
NPM 4 The percent of children with special health care needs age 0 to 18 whose families have

adequate private and/or public insurance to pay for the services they need.
NPM 5 The percent of children with special health care needs age 0 to 18 whose families report the community-based service system are organized so they can use them easily.
NPM 6 The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life.
NPM 7 Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.
NPM 9 Percent of third grade children who have received protective sealants on at least one permanent molar tooth.
NPM 13 Percent of children without health insurance.
NPM 14 Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.
NPM 17 Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.
NPM 18 Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.
SPM 12 Percent of infants with hearing loss who are receiving appropriate intervention services by age 6 months.
SPM 16 Percent of children aged 0-3 years who are developmentally delayed, or biologically or environmentally at risk who receive early intervention services to meet needs specified in the Individual Family Support Plan.

7. ENSURE THAT ALL CHILDREN 0-3 YEARS WHO ARE DEVELOPMENTALLY DELAYED, OR BIOLOGICALLY OR ENVIRONMENTALLY AT-RISK RECEIVE NEEDED EARLY INTERVENTION SERVICES.
The performance measure related to this priority is:
SPM 16 Percent of children aged 0-3 years who are developmentally delayed, or biologically or environmentally at risk who receive early intervention services to meet needs specified in the Individual Family Support Plan.

8. ENSURE THAT ALL INFANTS AND CHILDREN RECEIVE APPROPRIATE AND TIMELY HEARING EVALUATION AND EARLY INTERVENTION SERVICES.
The performance measures related to this priority are:
NPM 12 Percentage of newborns who have been screened for hearing before hospital discharge.
SPM 12 Percent of infants with hearing loss who are receiving appropriate intervention services by age 6 months.

9. ASSURE THAT PARENTING SUPPORT AND INFORMATION IS MADE AVAILABLE TO ALL FAMILIES WITH CHILDREN.
The performance measure related to this priority is:
SPM 14 The percent of families assessed to be at risk for child maltreatment that enroll in Hawai`i Healthy Start home visiting support services.

10. IMPROVE ASSESSMENT AND SURVEILLANCE OF MCH POPULATIONS, INCLUDING CHILDREN WITH SPECIAL HEALTH CARE NEEDS.
The performance measure related to this priority is:
SPM 15 Degree to which the MCH agency performs ten essential public health functions, as measured on a scale from 0-30.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			100	100	100
Annual Indicator			100.0	100.0	100.0
Numerator			8	12	9
Denominator			8	12	9
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100

Notes - 2004

Data is from the State Newborn Metabolic Screening Program, Department of Health. Since September 2003 Hawaii tests for 31 disorders.

a. Last Year's Accomplishments

One hundred percent of infants who were screened and confirmed with mandated newborn screening disorders received appropriate follow-up. On September 1, 2003, the newborn screening testing panel increased from 7 to 31 disorders. Additional urea cycle, organic acid, fatty acid oxidation and other amino acid disorders are now being screened with tandem mass spectrometry.

The Newborn Metabolic Screening Program (NBMSP) has oversight over the newborn metabolic screening system: obtaining blood specimens at hospitals, specimen transport, central laboratory testing, physician notification, and tracking. NBMSP staff tracked all infants who were diagnosed with metabolic and other disorders, had abnormal and unsatisfactory screening results, transferred to another facility, or were not screened. For infants who were confirmed with disorders, NBMSP identified the medical home, linked the medical home with the metabolic consultants, and followed-up with the medical home to ensure timely treatment.

Monthly newborn metabolic screening practice profiles were sent to birthing facilities and submitters, in an effort to decrease errors in transit time, timing of specimen collection, specimen quality, and reporting of demographic information. Birthing facilities use these screening practice profiles as a quality assurance tool. The screening practice profiles and updated information on newborn metabolic screening are also provided on the DOH website.

NBMSP participated in the CSHNB Genetics Program's project on the financial, ethical, legal, and social issues (FELSI) surrounding tandem mass spectrometry in newborn screening. The project utilized multi-state collaboration to identify strategies and develop educational materials for a culturally and ethnically diverse population. Project funding is from the MCH Bureau.

As of October 3, 2003, NBMSP can no longer obtain names of home birth parents identified through birth certificate data, in order to inform them of mandated newborn metabolic

screening. According to the Deputy Attorney General's interpretation HRS, Section 338-23, the Office of Health Status Monitoring cannot provide any birth certificate data other than name, sex, and type of vital event for quality assurance or other public health purpose that is not considered "research". The number of home births without screening is now unknown. There is a great potential for missed and/or delayed diagnosed cases in the home birth population and may contribute to a decrease in the number of infants being screened. In an effort to improve outreach to home birth parents, NBMSP conducted two educational sessions on the importance of newborn metabolic screening for midwives on Oahu and on Maui. To increase access to screening, NBMSP is also giving newborn screening kits without charge to midwives.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expand state mandated screening from 7 to 31 disorders.	X		X	
2. Contract for central laboratory testing.	X		X	X
3. Contract for transport of specimens to central laboratory.	X		X	X
4. Support genetics/metabolic clinics for children with metabolic disorders.	X	X		X
5. Follow-up/track infants with abnormal and unsatisfactory screening results or not screened.	X	X		
6. Follow-up with medical home to ensure timely treatment for infant with metabolic disorder.	X	X		
7. Update/distribute newborn metabolic screening brochure to birthing facilities and providers.			X	X
8. Update/distribute newborn screening practitioner's manual (guidelines) to primary care providers.			X	X
9. Conduct educational sessions for practitioners, nurses, laboratories, and birthing facilities.			X	X
10. Quality assurance with monthly screening practice profiles sent to birthing facilities/submitters.				X

b. Current Activities

NBMSP continues its oversight over the newborn metabolic screening system and continues to send out monthly newborn metabolic screening practice profiles to all the birthing facilities and submitters as a quality assurance tool. The transition to expanded newborn screening of 31 disorders went very smoothly. Three infants have benefited from the expanded tandem mass spectrometry screening. One infant has an organic acid disorder and two infants have fatty acid oxidation disorders. The overall newborn screening false positive rates for the additional amino acid, urea cycle, fatty acid oxidation, and organic acid disorders are very low.

The closure of the Queen's Medical Center Metabolic Clinic in May 2003 led to the formation of Hawaii Community Genetics (HCG), a private-public consortium, to develop genetic clinical services in the state. The Stanford geneticists are no longer staffing the genetic clinics at HCG, since Hawaii now has a full-time geneticist, who is the medical director of HCG, as of January 2005. NBMSP has committed $50,000/year for two years of its special funds to support HCG. CSHNB is contributing the services of Genetics Program genetic counselors several days per week, as well as services from the metabolic nutritionist and NBMSP coordinator.

A weekly comprehensive Thalassemia/Hemoglobinopathy Clinic will be starting in June 2005 at

HCG, to provide hematologic and genetic clinical services, and genetic counseling for infants and their families who are identified to have alpha thalassemia and/or other traits through newborn screening. NBMSP has committed $25,000/year for three years of its special funds to support the Thalassemia/Hemoglobinopathy Clinic. This Clinic will also provide comprehensive services and genetic counseling for infants diagnosed with sickle cell disease (SCD) and other significant hemoglobinopathies, as well as trait counseling and education. The Genetics Program was recently notified of a three year HRSA Sickle Cell Grant award, which will start in June 2005.

The FELSI grant ended on 5/31/05. Information obtained from the fourteen focus groups in four Western states (Hawaii, Alaska, California, and Oregon) were used to develop model educational materials. Hawaii's model newborn metabolic screening brochure is now being used to educate parents about newborn metabolic screening at the Baby Expo, health fairs, etc. Using these educational materials, a study will be conducted during the summer 2005 to determine whether prenatal patients read and retain newborn metabolic screening information via a brochure or a poster in the obstetrician's office. Prenatal care providers in the State will be provided with either brochures or posters, based on the results of this study.

Parent-oriented fact sheets on the urea cycle, other amino acid, organic acid, and fatty acid oxidation disorders were also developed by the FELSI Education Committee, and provided on the www.newbornscreening.info website.

c. Plan for the Coming Year

For infants who were confirmed with disorders, the NBMSP will continue to identify the medical home, link the medical home with the metabolic consultants, and follow-up with the medical home to ensure timely treatment. NBMSP will continue to work closely with the central laboratory and medical consultants to streamline procedures of notification and follow-up of test results.

NBMSP staff will continue to identify infants who did not receive newborn screening, based on "Specimen Not Obtained" forms and Hospital Monthly Newborn Screening Reports from birthing facilities, and will try to get these infants screened. NBMSP staff will also continue to provide education to health care providers, midwives, public health nurses, childbirth educators, and the general public about expanded newborn metabolic screening. NBMSP will utilize the Perinatal Advocacy Network, coordinated by Healthy Mothers/Healthy Babies Coalition, to disseminate information. More medical in-service sessions will be conducted to give feedback to the physicians regarding the findings of the expanded newborn screening program. Efforts will also be made to do more in-service education sessions with prenatal providers on expanded newborn screening testing, as mothers have clearly expressed the desire to learn about newborn metabolic screening from their prenatal care providers. NBMSP will also continue to provide more updated information on newborn metabolic screening on the websites.

NBMSP will continue to emphasize quality assurance by assisting each birthing facility to improve their newborn screening practice profiles through monthly reports and in-service sessions.

NBMSP will be actively participating in the Genetics Program's three-year Sickle Cell grant. Project activities include: improving the care of Hawaii infants with sickle cell disease or trait through comprehensive clinical services, genetic counseling, and education; developing and implementing a plan for long-term follow-up, support, and tracking of individuals detected by newborn screening; and developing and implementing a single gene counselor training, education, and certification program for sickle cell disease and trait.

NBMSP will also be participating in the Genetics Program's three-year Western States Genetic Services Collaborative grant. Project activities include refining, piloting, and evaluating a regional practice model that improves access to specialty genetic services (including use of telemedicine), comprehensive primary care, and care coordination for children with heritable conditions living far from comprehensive genetics and metabolic centers.

NBMSP will continue its participation in other CSHNB projects involving data integration and data linkages with such programs as Newborn Hearing Screening and Early Intervention.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			52.4	52.4	52.4
Annual Indicator			52.4	52.4	52.4
Numerator			10114	10114	10114
Denominator			19291	19291	19291
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	52.4	52.4	52.4	52.4	52.4

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS/National Survey of Children with Special Health Care Needs.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

The 2003 indicator is based on the State estimates from SLAITS/National Survey of Children with Special Health Care Needs.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

The 2004 indicator is based on the State estimates from SLAITS/National Survey of Children with Special Health Care Needs.

a. Last Year's Accomplishments

Families continue to be involved in various ways, including councils, task forces, and advisory

committees; development and review of parent education materials; participation in presentations and panels; participation in conferences and training sessions; interview panels for staff positions; advocacy for legislation; and input on proposed changes for policies and procedures. Parents are compensated or assisted in various ways including stipends, airfare and ground transportation for Neighbor Island families, and child care during activities. Family participants are of diverse ethnic and cultural backgrounds. Families were involved in councils and advisory committees, including Hawaii Early Intervention Coordination Council, Newborn Metabolic Screening Advisory Committee, Early Hearing Detection and Intervention Advisory Committee, and Healthy Child Care Hawaii Advisory Team.

The Hawaii Medical Home Implementation Project convened the first series of district meetings in various locations throughout the state, involving physicians, state/community agencies, and families of CSHCN. The Family Voices Co-Principal Investigator facilitated meetings, which looked at strengths, needs/issues/barriers to providing care, and areas where service delivery can be improved. The project videotaped 2 more family stories.

The CSHNB Chief attended the Family Voices Regional Workshop (Region IX) in Reno, Nevada, in February 2004. The meeting focused on data collection, development of leadership and mentoring, improving the youth transition system, serving underserved and under-represented populations, and engaging non-traditional partners.

The State Team for the Multi-State Meeting (June 2004) in Snowbird, Utah, included a Family Voices leader, pediatrician representing the American Academy of Pediatrics (AAP)-Hawaii Chapter and University of Hawaii (UH) Department of Pediatrics, and the Hawaii CSHCN Title V Director. The meeting, which included a focus on family partnership, provided an opportunity to further develop skills and knowledge regarding collaborative solutions, measurement, and data sources.

As part of the Title V five-year needs assessment for CSHCN, community meetings were held on Oahu and the Neighbor Islands (Hawaii, Kauai, Maui) from June-August 2004. Participants include families, Family Voices, and key state and community agencies and organizations. Participants provided their input on strengths, needs, and opportunities for each of the six outcomes for CSHCN. The Family Voices State Coordinator facilitated the meetings and analyzed responses.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Involve family members in councils, task forces, and advisory and planning committees.				X
2. Involve family members in presenting a family viewpoint at workshops and training sessions.				X
3. Compensate family members for participation, e.g., stipend, transportation costs, and child care.		X		
4. Support opportunities for family members to attend local/national conferences and workshops.		X		
5. Include family members as panel members in interviews for staff positions.				X
6. Involve family members in developing and reviewing parent education				X

materials.				
7. Involve/support families in advocating for policy change (e.g., testify at legislative hearing).		X		X
8. Disseminate Hawaii data on family partnership from the National Survey of CSHCN.				X
9. Use Hawaii data on family partnership in planning/improving outcomes for CSHCN.				X
10. Provide information/training to families, providers, and programs on resources and services for CSHCN and on navigating the system of services.				

b. Current Activities

CSHNB and Family Voices, with AAP-Hawaii Chapter and UH/School of Medicine/Department of Pediatrics, applied for and received funding from the MCH Bureau for a Hilopa`a Project-Integrated Services for Children and Youth with Special Health Care Needs (CYSHCN). The project aims to improve the access for CYSHCN and their families to quality, comprehensive, coordinated, and community-based systems of services, using an integrated approach in addressing the six core outcomes for CSHCN.

CSHNB is participating in developing the Early Childhood Comprehensive Systems Plan, which includes an objective to "Support and strengthen families to nurture their child's development". Activities are now being planned.

The Hawaii Medical Home Implementation Project completed its second series of district meetings in various locations throughout the state. The project is now providing training sessions on the PEDS developmental screening tool to pediatricians and their office staff in various areas on Oahu, Kauai, Maui, and Hawaii; a family representative is assisting in providing the training. The project completed a Family Story DVD and disseminated it locally and nationally. One of the family stories was presented by the Project Coordinator at a Medical Home training in the Philippines.

The 2005 State Legislature passed a resolution requesting a study of access to community-based specialty care on the neighbor islands and in rural Oahu. The resolution was initiated by the Family Voices State Coordinator, to address a need identified during the Title V CSHCN needs assessment process.

CSHNB received an incentive grant from the Champions for Progress Center for a project to establish core transition principles, develop a transition framework and checklist, and develop family leadership skills and family/professional partnerships. Professional and family leaders serve as co-committee chairpersons.

Hawaii Maternal and Child Health Leadership in Education in Neurodevelopmental and Related Disabilities (MCH LEND) Program prepares health professionals for leadership roles to improve supports/services for CSHCN. During the 2004-2005 academic year, trainees explored issues for medically fragile children in their transition from hospital to home. Trainees interviewed and videotaped family stories, researched the service system, and presented their findings at the Pac Rim Conference on Disabilities.

c. Plan for the Coming Year

The Hilopa`a Project will begin implementation. Project activities to improve family partnership in decision-making and satisfaction with services include: develop and implement a "One Stop/Transition Certification" for programs, agencies, providers and families whose framework is based upon the best practices, protocols, and standards for referral and transition for

programs in DOH and DHS or their contracted providers; develop and provide training on navigating the system for families of CSHCN age 0-3 and families for middle school youth with special health care needs prior to age 14; enhance current opportunities for family support and training to better meet the needs of families in their communities; develop a resource pool of parents and self-advocates to be strategically linked to programs serving CSHCN to participate as trainers, family representatives and partners; and convene a paid "Youth Advisory Committee" of 6-9 youths/self-advocates to develop personal leadership, self determination and community advocacy skills.

The Champions incentive grant award project will continue, and work will be integrated and coordinated with the Hilopa`a Project.

Families will continue to be involved in various ways, including councils, task forces, and advisory committees; development and review of information materials for parents; participation in presentations and panels; participation in conferences and training sessions; interview panels for staff positions; advocacy for legislation; and input on proposed changes for policies and procedures.

MCH LEND activities will include:
- In conjunction with the Hilopa`a Project and the State QUEST Expanded Advisory Council, MCH LEND trainees will conduct focus groups of families of CSHCN and potentially some youth to explore their understanding of Managed Care. The findings will be used to design outreach materials and training curriculum which will be incorporated into the state's request for proposal to procure outreach services to facilitate the transition to managed care. Findings will also be provided to prospective health plans to better understand their future client base.
- Trainees will assist in planning and implementing the State Council on Developmental Disabilities annual "Day at the Capitol" to encourage family members and self- advocates to meet their legislators. Trainees will recruit families of children/youth age 0-21 to augment the large adult consumer population that attends on a regular basis, and will work with families to develop materials for table top displays.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			47.9	47.9	47.9
Annual Indicator			47.9	47.9	47.9
Numerator			14657	14657	14657
Denominator			30627	30627	30627
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**

Annual Performance Objective	47.9	47.9	47.9	47.9	47.9

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS/National Survey of Children with Special Health Care Needs.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

The 2003 indicator is based on the State estimates from SLAITS/National Survey of Children with Special Health Care Needs.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

The 2004 indicator is based on the State estimates from SLAITS/National Survey of Children with Special Health Care Needs.

a. Last Year's Accomplishments

The Medical Home Implementation Project for CSHCN is a collaborative effort of the American Academy of Pediatrics (AAP)-Hawaii Chapter, Family Voices of Hawaii, and DOH/CSHNB. The Project convened community meetings with physicians, families, and state/community agencies, to identify strengths, needs/issues/barriers to providing care, and how service delivery can be improved. Meetings were held in various locations on the islands of Kauai, Hawaii, and Oahu. Follow-up included addressing some of the identified issues and barriers to services. Work began on a Family Story DVD which focuses on the medical home.

The Early Childhood Comprehensive Systems (ECCS) planning grant included a medical home component. For the ECCS conference "Charting the Future: Connecting the Stars for Our Children" in May 2004, CSHNB developed the fact sheet on "Medical Home", and the CSHNB Chief presented data on young CSHCN. The Medical Home Implementation Project Co-Principal Investigator (Family Voices State Coordinator) and Project Coordinator facilitated the breakout session on Medical Home.

The Health and Early Childhood Committee of the State Council for Developmental Disabilities, under an objective to improve community support services, added a new activity to encourage efforts to assure a medical home for every young child with developmental disabilities. This committee includes representatives from CSHNB, Developmental Disabilities, University of Hawaii (UH) Center on Disability Studies, and Department of Human Services/Med-QUEST Division.

The medical home concept has been incorporated into pediatric resident training. The UH Department of Pediatrics/Integrated Pediatric Residency Program offers pediatric residents training that integrates a medical home approach throughout the three years of training.

CSHNB programs incorporated the medical home into program services. For example, for infants who were confirmed with metabolic disorders, the Newborn Metabolic Screening Program identified the medical home, linked the medical home with metabolic consultants, and followed-up to ensure timely treatment.

Kamehameha Schools and UH Department of Pediatrics began planning conferences on developmental screening for pediatricians, other health care providers, early childhood community providers, and key policy makers. The FHSD and CSHNB Chiefs were involved in

planning the early childhood/school readiness conference for community partners.

The State Team for the Multi-State Meeting (June 2004) in Snowbird, Utah, included a Family Voices leader, pediatrician representing the AAP-Hawaii Chapter and UH/Department of Pediatrics, and the Hawaii CSHCN Title V Director. The meeting, which included a focus on the medical home core outcome, provided an opportunity to further develop skills and knowledge regarding collaborative solutions, measurement, data sources, and system-building.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Incorporate the medical home into direct/enabling services with families.	X	X		
2. Incorporate the medical home concept in planning/structure of programs and services.				X
3. Identify/address issues and barriers to service delivery, to support care by medical home.				X
4. Disseminate Hawaii data on medical home from the National Survey of CSHCN and National Survey of Children's Health.				X
5. Participation in planning/activities of Medical Home Implementation Project.				X
6. Analyze/disseminate Hawaii data on medical home from the National Survey of CSHCN.				X
7. Use Hawaii data on medical home in needs assessment and planning toward improving outcomes for CSHCN.				X
8.				
9.				
10.				

b. Current Activities

The Medical Home Implementation Project convened community meetings with physicians, families of CSHCN, state/community agencies, to identify strengths, needs/issues/barriers to providing care, and how service delivery can be improved. Meetings were held on the islands of Kauai, Hawaii (Hilo, Kona), and Oahu (Waianae, Central, Leeward, Windward). Follow-up includes addressing some of the identified issues and barriers to services.

The Medical Home Implementation Project convened community meetings in various locations statewide with physicians, families, and state/community agencies, to identify strengths, issues in providing care, and how service delivery can be improved. Follow-up included addressing some of the issues and barriers to services. The project completed a Family Story DVD and disseminated it locally and nationally. One of the family stories was presented by the Project Coordinator at a Medical Home training in the Philippines. The project is providing training sessions on the PEDS developmental screening tool to pediatricians and their office staff in various areas on Oahu, Kauai, Maui, and Hawaii.

CSHNB and Family Voices, with AAP-Hawaii Chapter and UH/School of Medicine/Department of Pediatrics, applied for and received funding from the MCH Bureau for a Hilopa`a Project-Integrated Services for Children and Youth with Special Health Care Needs (CYSHCN). The project aims to improve the access for CYSHCN and their families to quality, comprehensive,

coordinated, and community-based systems of services, using an integrated approach in addressing the six core outcomes for CSHCN.

The AAP-Hawaii Chapter established a Medical Home Committee. A project may include website development to promote interest in screening, surveillance, early identification, and follow-up care for CSHCN.

The AAP-Hawaii Chapter's October 2004 "Hawaii Pediatric Conference" for pediatricians included sessions by Drs. Paul Dworkin and Frances Glascoe on developmental screening/surveillance, tools, and challenges. The UH/Department of Pediatrics and Kamehameha Schools presented a related conference for community providers on "Early Steps to School Readiness".

For the Early Childhood Comprehensive System Plan, CSHNB, MCHB, AAP-Hawaii Chapter, UH Department of Pediatrics, Medical Home Implementation Project, and Healthy Child Care Hawaii representatives collaboratively developing activities for the objective to "Assure universal surveillance, periodic screening and effective follow-up for children ages birth to five years". Activities are now being planned for another ECCS objective to "Ensure children have access to medical and dental homes".

Hawaii data on medical home from the National Survey of CSHCN and National Survey of Children's Health were analyzed and are available in written reports.

The Health and Early Childhood Committee of the State Council for Developmental Disabilities includes a focus on encouraging efforts to assure a medical home for every y

c. Plan for the Coming Year

The Hilopa`a Project will begin implementation. Project activities with a medical home component include: develop and implement a "One Stop/Transition Certification" Program for programs, agencies, providers and families which includes the best practices, protocols, and standards for referral and transition for state/community programs; implement a curriculum for Community Pediatric and Family Practice Residents which extends teaching the knowledge, skills, and attributes of the Medical Home to include the physician role in an integrated service system; provide trainings to physicians and programs/agencies statewide on the PEDS screening tool, and best practices, protocols, and standards for the integrated referral process. Hilopa`a Project continues and expands on the work on the Medical Home Implementation Project, which is near the end of its funding cycle.

The Health and Early Childhood Committee of the State Council for Developmental Disabilities will address activities to encourage efforts to assure a medical home for every young child with developmental disabilities.

The pediatric resident training will continue to incorporate the medical home concept.

For the Early Childhood Comprehensive Systems Plan, CSHNB will participate in developing the activities related to the objectives on screening and medical/dental homes.

CSHNB programs will continue to promote the medical home concept in various planning efforts and program services.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need.*

(CSHCN Survey)

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			70.2	70.2	70.2
Annual Indicator			70.2	70.2	70.2
Numerator			21980	21980	21980
Denominator			31318	31318	31318
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	70.2	70.2	70.2	70.2	70.2

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS/National Survey of Children with Special Health Care Needs.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

The 2003 indicator is based on the State estimates from SLAITS/National Survey of Children with Special Health Care Needs.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

The 2004 indicator is based on the State estimates from SLAITS/National Survey of Children with Special Health Care Needs.

a. Last Year's Accomplishments

Care coordinators/program staff provided information and assisted uninsured CSHCN/families in obtaining health coverage from public sources, including QUEST managed care for Medicaid-eligible children, including the State Child Health Insurance Program (SCHIP) for children with family income less than 200% FPL; fee-for-service (FFS) for Medicaid-eligible children with disabilities; QUEST-Net for children who lost QUEST/FFS coverage due to increasing income or assets; and Home and Community-Based Services waivers.

As a safety net and to increase access to services, Children with Special Health Needs Program (CSHNP) provided medical specialty, laboratory, x-ray, hearing aids, cardiac and neurology clinics on Neighbor Islands, and air/ground transportation. CSHNP is administering the Hawaii Lions Foundation Uninsured/Under-Insured Fund for hearing and vision services. Newborn Metabolic and Newborn Hearing Screening Programs paid for screening and follow-up diagnostic evaluations for families who cannot afford the cost. Preschool Development Screening Program provided developmental and behavioral screening for children and assisted

with follow-up for concerns.

Early Intervention Section (EIS) provided psychological, audiological, physical/occupational therapy, speech, nutrition, vision, assistive technology, transportation, and other services for children age 0-3 with or at biological/environmental risk for developmental delays (mandated by Part C of IDEA). Services for QUEST-eligible children are reimbursed through a Medicaid-funded carved-out, capitated plan. EIS administers the DOH respite funding for children age 0-3 years with developmental delays and children age 0-21 years with serious/chronic illness.

Hawaii Covering Kids continued its efforts that began in 1999 toward a seamless enrollment process for children and youth eligible for Medicaid/QUEST. Activities included outreach programs.

Hawaii Uninsured Project is a collaborative effort to design workable plans to ensure that all Hawaii residents have access to health care coverage. Project partners include state/local government, health care plans and providers, business, research, and community organizations.

The State Team for the Multi-State Meeting (June 2004) in Snowbird, Utah, included a Family Voices leader, pediatrician representing the American Academy of Pediatrics-Hawaii Chapter and University of Hawaii (UH) Department of Pediatrics, and the Hawaii CSHCN Title V Director. The meeting, which included a focus on the health insurance core outcome, provided an opportunity to further develop skills and knowledge regarding collaborative solutions, measurement, data sources, and system-building.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide information and assist uninsured CSHCN/families in obtaining health insurance.		X		
2. Promote access to health insurance for families of uninsured children in child care settings.		X		X
3. Provide information/assist families in accessing other public resources, e.g., SSI, Medicaid waivers.		X		
4. Provide/contract medical and other health services as a safety net for uninsured and underinsured CSHCN.	X	X		X
5. Identify/address issues/barriers of CSHCN in accessing insurance/services to meet needs.				X
6. Support legislative efforts to provide/mandate services when insurance does not meet family needs.				X
7. Disseminate Hawaii data on health insurance from the National Survey of CSHCN and National Survey of Children's Health.				X
8. Use Hawaii data on health insurance in the development and implementation of plans to improve outcomes for CSHCN.				X
9. Use Hawaii data on health insurance in planning/improving outcomes for CSHCN.				X
10. Provide training which includes a health insurance component, to programs, agencies, providers and families on navigating the system and on best practices, protocols, and standards for referral and transition.				

b. Current Activities

The Department of Human Services (DHS) is amending the QUEST program to include enrolling the Aged, Blind, and Disabled (ABD) population into managed care plans, raising the upper income limit for SCHIP, and changing its QUEST-Net requirements so that all children with family incomes at or below 300% FPL will be eligible for the QUEST benefit package. The enrollment of the ABD population into managed care is scheduled for July 2007. DHS is providing updates to state/community agencies and providers at QUEST Expanded Roundtables. DHS has established an Advisory Council regarding implementation. The Family Voices State Coordinator gave a presentation on "Community Perspective: Hawaii's System of Care for Children Who Are Medically Fragile" to prospective health plans

Hawaii Covering Kids is continuing activities to increase the number of eligible children who benefit from health insurance programs. Its flyer is now available in 16 languages. Outreach has included providing information to high school athletic directors, partnering with the Department of Parks and Recreation to hang posters and distribute flyers, provide information to pharmacies, and conducting enrollment training workshops with community organization.

The American Academy of Pediatrics-Hawaii Chapter established a Pediatric Council, with participation by Medical Directors from 5 health plans, State Legislators, Department of Health, State Insurance Commissioner, and Family Voices, to address insurance issues.

The Children with Special Health Needs Program (CSHNP) audiologist worked with DHS Med-QUEST Division (MQD) on the Medicaid coverage for hearing aids. Following the CSHNP model, MQD arranged with a hearing aid manufacturer for discounted rates, which resulted in Medicaid fee-for-service changes including coverage for digital hearing aids for children, manufacturer hearing aid loss/damage extended warranty, manufacturer hearing aid accessories without charge with the initial purchase of hearing aids, and a clearer process for prior authorization. Medicaid arranged with the CSHNP audiologist to make available hearing aids for "trials".

CSHNB and Family Voices, with AAP-Hawaii Chapter and UH/School of Medicine/Department of Pediatrics, applied for and received funding from the MCH Bureau for a Hilopa`a Project-Integrated Services for Children and Youth with Special Health Care Needs (CYSHCN). The project aims to improve the access for CYSHCN and their families to quality, comprehensive, coordinated, and community-based systems of services, using an integrated approach in addressing the six core outcomes for CSHCN.

Health providers and program/agency staff continue to provide information and assist uninsured families in obtaining Medicaid/QUEST and/or other health care coverage.

CSHNB programs continue to provide direct and enabling services as a safety net and to increase access to services, especially for those without other resources.

c. Plan for the Coming Year

The Hilopa`a Project will be implemented. Project activities with an insurance component include developing and implement a "One Stop/Transition Certification" Program for programs, agencies, providers and families which will include best practices, protocols, and standards for referral and transition for programs in DOH and DHS or their contracted providers; and developing and providing training on navigating the system for families of CSHCN age 0-3 and families for middle school youth with special health care needs prior to age 14.

CSHNB will track activities of the Hawaii Uninsured Project, Hawaii Covering Kids, and possible Health Care Task Force.

Health providers and program/agency staff will continue to provide information and assist uninsured families in obtaining Medicaid/QUEST and/or other health care coverage.

CSHNB programs will continue to provide direct and enabling services as a safety net and to increase access to services, especially for the uninsured and underinsured. These services include medical specialty and other services (CSHNP), newborn screening and follow-up diagnostic evaluations (Newborn Metabolic and Newborn Hearing Screening Programs), developmental and behavioral screening (Preschool Development Screening Program), and respite services (EIS/Respite Program). EIS will continue to provide early intervention services as mandated by Part C of IDEA.

The Hawaii Maternal and Child Health Leadership in Education in Neurodevelopmental and Related Disabilities (MCH LEND) Program at the UH/Center of Disability Studies prepares health professionals for leadership roles to improve supports and services for CSHCN. In conjunction with the Hilopa`a Project and the State QUEST Expanded Advisory Council, MCH LEND trainees will conduct focus groups of families of CSHCN and potentially some youth to explore their understanding of Managed Care. The findings will be used to design outreach materials and training curriculum which will be incorporated into the state's request for proposal to procure outreach services to facilitate the transition to managed care. Findings will also be provided to prospective health plans to better understand their future client base.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			69.2	69.2	69.2
Annual Indicator			69.2	69.2	69.2
Numerator			13319	13319	13319
Denominator			19257	19257	19257
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	69.2	69.2	69.2	69.2	69.2

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS/National Survey of Children with Special Health Care Needs.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

The 2003 indicator is based on the State estimates from SLAITS/National Survey of Children with Special Health Care Needs.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

The 2004 indicator is based on the State estimates from SLAITS/National Survey of Children with Special Health Care Needs.

a. Last Year's Accomplishments

CSHNB programs work toward statewide coordinated, family-centered services/systems:
- Early Intervention Section is the lead agency for Part C/IDEA mandated early intervention services for infants/toddlers. The statewide system includes central directory, public awareness, child find, evaluation/assessment procedures, Individual Family Support Plan, personnel development/standards, procedural safeguards, program supervision/monitoring, complaint resolution, financial policies, interagency agreements, data collection.
- Newborn Hearing Screening Program is responsible for the statewide system of newborn hearing screening and followup, including protocols to assure timely screening, diagnostic audiological evaluation, and link to early intervention services; technical assistance; quality assurance; data/tracking; professional/public education; and evaluation.
- Newborn Metabolic Screening Program is responsible for the statewide system of newborn metabolic screening, including standards and procedures for timely screening, diagnosis, and intervention/followup; data/tracking; quality assurance; and professional/public education.
- Preschool Developmental Screening Program promotes early identification for developmental/behavioral problems for children age 3-5 years. The program trains community providers in standardized screening, and assists in follow-up.
- Children with Special Health Needs Program provides medical specialty, nutrition, social work, craniofacial review, pediatric cardiac and neurology clinics on Neighbor Islands, and other services, as a "safety net" and to increase access to services.

Medically Fragile Coordinating Committee is working toward a seamless continuum of care for medically fragile technology-dependent children. It convened a conference "The Community Connection -- Caring for the Medically Fragile/Technology Dependent Child in November 2003.

Hawaii Covering Kids is working toward a seamless enrollment process for children and youth eligible for Medicaid/QUEST.

Hawaii Uninsured Project is a collaborative effort to ensure that all Hawaii residents have access to health coverage.

Title V/CSHCN needs assessment community meetings were held on Oahu and the Neighbor Islands from June-August 2004. Participants include families, Family Voices, pediatricians, and state/community agencies and organizations. Participants provided input on strengths, needs, and opportunities related to the six outcomes for CSHCN.

Medical Home Implementation Project completed community meetings with physicians, families, and state/community agencies, to identify strengths, issues, and how service delivery can be improved. Follow-up included addressing some of the issues and barriers to services.

The Multi-State Meeting (June 2004) in Snowbird, Utah, which included a focus on the system of services, provided an opportunity to further develop skills and knowledge regarding

collaborative solutions, measurement, data sources, and system-building.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide medical specialty and other services as a safety net for CSHCN who have no other resources, and to increase access to services.	X	X		X
2. Improve coordination of health, education, social, and other services for CSHCN.		X		X
3. Advocate/work toward increasing resources to meet increased need or gaps in availability of services.				X
4. Provide education/training on services/resources for CSHCN.				X
5. Establish and maintain collaborative partnerships to address improving outcomes for CSHCN.				X
6. Disseminate Hawaii data on services system issues from the National Survey of CSHCN and National Survey of Children's Health.				X
7. Use Hawaii data on organization of services in needs assessment and planning toward improving outcomes for CSHCN.				X
8. Obtain information and provide training on community resources and navigating the system of services				
9.				
10.				

b. Current Activities

CSHNB and Family Voices, with AAP-Hawaii Chapter and UH/School of Medicine/Department of Pediatrics, applied for and received funding from the MCH Bureau for a Hilopa`a Project-Integrated Services for Children and Youth with Special Health Care Needs (CYSHCN). The project aims to improve the access for CYSHCN and their families to quality, comprehensive, coordinated, and community-based systems of services, using an integrated approach in addressing the six core outcomes for CSHCN.

CSHNB programs continue to strive toward statewide coordinated, family-centered services/systems. EIS is tracking funding/expenditures to document the increased need for resources to serve the increased number of children needing services, and is focusing on the requirements of Part C/IDEA.

Hawaii Community Genetics (HCG) is a partnership of DOH/CSHNB Genetics Program, Kapiolani Medical Center for Women and Children (KMCWC), Queen's Medical Center, and UH School of Medicine to develop clinical genetics and metabolic services in Hawaii. HCG has successfully recruited a full-time geneticist for clinical services. Clinical genetics services are expanding with the addition of a hemoglobinopathy clinic, neighbor island clinics, and telemedicine visits.

The Medically Fragile Coordinating Committee includes the DOH, Department of Human Services, KMCWC, and other health care organizations. Improving community case management has included addressing roles and responsibilities of hospital case management vs. that of community case management providers, and simplifying forms and procedures.

The Medical Home Implementation Project is providing training sessions on the PEDS developmental screening tool to pediatricians in various areas on Oahu, Kauai, Maui, and Hawaii, along with information about appropriate referrals to Early Intervention services, Preschool Developmental Screening Program, and Department of Education special education preschool.

CSHNB participates in the Early Childhood Comprehensive System effort to develop a state plan.

To study factors contributing to difficulty using community-based services by families of CSHCN in Hawaii, data from the National Survey of CSHCN (2001) were analyzed by the UH Department of Public Health, FHSD/MCH Epidemiologist, and DOH/CSHNB. Analysis showed that lack of involvement in decision-making, lack of coordinated care in a medical home and insufficient health insurance were the main obstacles to their ability to use community-based services easily. The article has been accepted for publication in the Maternal and Child Health Journal.

The 2005 State Legislature passed a resolution requesting a study to improve access to community-based specialty care on the neighbor islands and in rural Oahu. The resolution was initiated by the Family Voices State Coordinator to address a need identified during the Title V CSHCN needs assessment process.

c. Plan for the Coming Year

The Hilopa`a Project will begin implementation. Project activities to improve the organization of community-based service systems so that families can use them easily include: develop and implement a "One Stop/Transition Certification" for programs, agencies, providers and families whose framework is based upon the best practices, protocols, and standards for referral and transition for state/community programs; develop and provide training on navigating the system for families of CSHCN age 0-3 and families for middle school youth with special health care needs prior to age 14; enhance current opportunities for family support and training to better meet the needs of families in their communities; develop a resource pool of parents and self-advocates to be strategically linked to programs serving CSHCN to participate as trainers, family representatives and partners; convene a paid "Youth Advisory Committee" of 6-9 youths/self-advocates to develop personal leadership, self determination and community advocacy skills; implement a Residency Curriculum which extends teaching the knowledge, skills, and attributes of the Medical Home to include the role of the Medical Home in an integrated service system, for Community Pediatric and Family Practice Residents; and continue trainings to physicians statewide on the PEDS screening tool and best practices, protocols, and standards for the integrated referral process.

Current efforts will continue, including those for CSHNB programs (Early Intervention Section, Newborn Hearing Screening Program, Newborn Metabolic Screening Program, Preschool Developmental Screening Program, Children with Special Health Needs Program, and Genetics Program) to provide services as a safety net for CSHCN and to increase access to services; increasing resources to meet increased need or gaps in availability of services; education/training on services and resources for CSHCN; improving coordination of health, education, social, and other services for CSHCN.

CSHNB, UH Department of Pediatrics, AAP-Hawaii Chapter, and Family Voices will continue collaborative efforts for the Hilopa`a Project and other areas to improve outcomes for CSHCN.

Other continuing efforts include the Early Childhood Comprehensive System planning and implementation, Medically Fragile Task Force, and others.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			5.1	5.1	5.1
Annual Indicator			5.1	5.1	5.1
Numerator			351	351	351
Denominator			6937	6937	6937
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5.1	5.1	5.1	5.1	5.1

Notes - 2002

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

The 2003 indicator is based on the State estimates from SLAITS/National Survey of Children with Special Health Care Needs.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

The 2004 indicator is based on the State estimates from SLAITS/National Survey of Children with Special Health Care Needs.

a. Last Year's Accomplishments

Transition begins in early childhood. Early Intervention Section (EIS) provided transition training to EIS staff, Department of Education (DOE) Preschool Special Education and Student Support Coordinators, Head Start, Healthy Start, community preschools, and family members. The Early Intervention Orientation included one day on transdisciplinary service provision, teaming, and transition. EIS staff provided transition planning and services/supports for children with developmental delays exiting from Part C early intervention services.

EIS care coordinators provided information and assistance with Supplemental Security Income (SSI) referral to families of children age 0-3 with developmental delays. Families of children who may qualify were given information about SSI and how to apply. Care coordinators

assisted families in applying for SSI if requested.

Social workers and other health professionals in the Children with Special Health Needs Program (CSHNP) provided outreach services to medically eligible SSI applicants less than age 16 years referred by the Disability Determination Branch of the Department of Human Services (DHS), and to SSI beneficiaries referred by other community resources.

Several CSHNP staff meetings focused on the transition to adult health care, work, and independence, with information/discussion of transition issues, planning, tools, and Hawaii data.

Transition services were provided for special education students in the Department of Education, with the Individualized Education Plan (IEP) including the student's transition service needs and interagency responsibilities or linkages.

The University of Hawaii (UH)/School of Medicine has a combined Internal Medicine/Pediatrics residency program. This helps to increase the number of physicians able to provide services for individuals of all ages, including youths with special health care needs transitioning to adult health care.

The State Team for the Multi-State Meeting (June 2004) in Snowbird, Utah, included a Family Voices leader, pediatrician representing the American Academy of Pediatrics (AAP)-Hawaii Chapter and UH Department of Pediatrics, and the Hawaii CSHCN Title V Director. The meeting, which included a focus on the transition core outcome, provided an opportunity to further develop skills and knowledge regarding collaborative solutions, measurement and data sources.

Hawaii data from the National Survey of CSHCN were analyzed. The report, completed in May 2004, included data on transition.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide transition planning and support as children/youth exit program services to other settings/services.		X		
2. Provide information, assist children/youth/families in accessing public resources, e.g. SSI or DD/MR waiver.		X		
3. Provide outreach to SSI/medically eligible children under 16 referred by Disability Determination Branch.		X		
4. Provide training/information on transition planning and support when children exit from Part C services to other settings.		X		X
5. Provide training/information on strategies for successful transition, including work, independence, and adult health care.				X
6. Participate and coordinate with other transition services/projects in community.				X
7. Disseminate Hawaii data on transition from the National Survey of CSHCN and National Survey of Children’s Health.				X
8. Use Hawaii data on transition in planning/improving outcomes for CSHCN				X

9.				
10.				

b. Current Activities

CSHNB received an incentive grant from the Champions for Progress Center for a transition project to establish core transition principles, develop a framework and checklist for transition areas, and develop family leadership skills and family/professional partnerships. Committees, with professional and family leaders as committee chairpersons, focus on transitions including between state and community programs, hospital to home, and pediatric to adult health care.

CSHNB and Family Voices, with AAP-Hawaii Chapter and UH/School of Medicine/Department of Pediatrics, applied for and received funding from the MCH Bureau for a Hilopa`a Project-Integrated Services for Children and Youth with Special Health Care Needs (CYSHCN). The project aims to improve the access for CYSHCN and their families to quality, comprehensive, coordinated, and community-based systems of services, using an integrated approach in addressing the six core outcomes for CSHCN.

EIS continues to provide and/or assist with transition training. The three-day Early Intervention Orientation includes one day of information on transdisciplinary service provision, teaming, and transition; this training is provided for early interventionists, public health nurses, and Healthy Start providers. EIS staff continue to provide transition planning and services/supports when children exit from Part C early intervention services, and continue to provide information and assistance to families with SSI referral.

CSHNP social workers and other health professionals continue to provide outreach services to medically eligible SSI applicants less than age 16 years referred by DHS Disability Determination Branch, and to SSI beneficiaries referred by other community resources.

Transition services continue to be provided for special education students in the DOE.

The UH Internal Medicine/Pediatrics residency program continues its training.

CSHNB is participating on the Advisory Board for Successful Transitions in Diverse Environments (STRIDE) Mentoring Project to design, develop, implement, and evaluate an effective vocational rehabilitation model for mentoring culturally-diverse youth and young adults with disabilities as they transition into meaningful community environments, post-secondary education or employment.

CSHNB is participating on the Advisory Council for the Hawaii 360 Youth and Family Project, which is implementing a pilot project to design and implement a Navigational One-Stop System in Hawaii for transitioning youth with developmental disabilities and their families.

c. Plan for the Coming Year

The Hilopa`a Project will begin implementation. Project activities with transition component include: document in Rainbow Book II the best practices, protocols, and standards for coordinated care, including transition, between programs and agencies that serve CYSHCN; provide training on "Navigating the System", which includes transition, to families of CSHCN age 0-3 years and to families of middle-school youth prior to age 14 years; develop a "One Stop/Transition Certification" for programs, agencies, and providers, based on the framework documented in Rainbow Book II; establish a Youth Advisory Council that develops personal leadership, self-determination, and community advocacy skills, provide medical home curriculum and training that includes transition, for pediatric and family physician residents. Implement best policies, practices, and standards on transitioning YSHCN to adult health care in selected pediatric and family physician residents; implement best policies, practices, and

standards on transitioning YSHCN to adult health care in selected pediatric and family physician practices.

The Champions incentive grant award project will continue, and work will be integrated with the Hilopa`a Project.

EIS will continue to provide information and assistance to families with SSI referral, and provide transition planning and services/supports for children exiting from Part C early intervention services. Transition training will continue.

CSHNP social workers and other health professionals will continue to provide outreach services to medically eligible SSI applicants less than age 16 years referred by DHS Disability Determination Branch, and to SSI beneficiaries referred by other community resources. CSHNP will continue to include a focus on the transition to adult health care, work, and independence, and to include transition planning in staff services with youth/families.

Transition services will continue to be provided for special education students in the Department of Education.

The UH Internal Medicine/Pediatrics residency program continues its training of physicians.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	83	77	76.9	77.2	77.9
Annual Indicator	75.8	72.8	78.1	79.1	82.9
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	78.3	78.6	79	79.3	79.7

Notes - 2002

Data from 1996-1998 reports on immunization series 4:3:1:3. Data from 1999 reports on immunization series 4:3:1:3:3. Data comes from the U.S. National Immunization Survey, CDC. The survey reports the percentage of estimated state vaccination coverage, but does not provide the numerators and denominators used in the calculations. The FY 2002 indicator is provisional data from July 2001-June 2002. The data will be updated for the full 2002 calendar

year when available. FY 2001 indicator was updated to reflect full calendar year data.

The annual performance objectives have been modified. An annual pace has been blueprinted to meet the Healthy People 2010 objective for this measure.

Notes - 2003

Data from 1996-1998 reports on immunization series 4:3:1:3. Data from 1999 reports on immunization series 4:3:1:3:3. Data comes from the U.S. National Immunization Survey, CDC. The survey reports the percentage of estimated state vaccination coverage, but does not provide the numerators and denominators used in the calculations. The data from 1999 was revised using the period “coverage among children 19-35 months” rather than the “coverage by 24 months” period. The annual performance objectives were also revised.

An annual pace has been blueprinted to meet the Healthy People 2010 objective for this measure.

Notes - 2004

Data from 1999 reports on immunization series 4:3:1:3:3. Data comes from the U.S. National Immunization Survey, CDC. The survey reports the percentage of estimated state vaccination coverage, but does not provide the numerators and denominators used in the calculations.

The annual performance objectives have been modified. An annual pace has been blueprinted to meet the Healthy People 2010 objective for this measure.

Data for FY 2000-2002 was revised to conform to the Title V measure tracking immunizations for infants 19 to 35 months. Previously, data was reported for infants up to 2 years of age.

a. Last Year's Accomplishments

Preliminary data from the National Immunization Survey (NIS) indicate that 82.9% of children ages 19-35 months have completed the recommended schedule of immunizations in Hawaii. The FY04 objective of 77.9% was exceeded. Hawaii compares well to the national rate of 80.5% for the same period.

Given the high percentage of insured children (97.1% in 2004), the rates should be much higher. Moreover, State law requires all health insurance policies issued in Hawaii that cover children must provide routine immunizations from birth through age five years

Ongoing direct services to increase child immunizations include safety-net programs such as immunization clinics supported by Department of Health (DOH) Public Health Nursing and the federally funded Vaccines for Children Program at the primary care health centers that serve those without health insurance or children with Medicaid coverage.

Ongoing enabling services include parent education, referral and follow-up for immunizations through purchase-of-service contracts administered by the Title V agency for primary care services for the uninsured, Healthy Start, and WIC. The Hawaii Covering Kids initiative, funded by the Robert Wood Johnson Foundation, continues to expand its outreach efforts to enroll uninsured children into Med-QUEST.

Within the DOH, the Hawaii Immunization Program (HIP) is the lead agency for children's immunization. HIP administers state and federally funded vaccine programs, provides information on immunization schedules, vaccination availability, immunization policies and works to promote collaboration. HIP continues to mail out about 5,000 "Protect Your Keiki Now" immunization reminders monthly to parents of children ages 0, 4, and 12 months. The Title V agency works closely with HIP on population based and infrastructure development activities.

Statewide, population-based services focus on increasing public awareness and include the

outreach efforts of the Hawaii Immunization Coalition's (HIC) Infant Immunization Sub-Committee. HIC is a statewide, community-based coalition of public and private organizations and concerned individuals whose mission is to promote effective strategies to ensure that all of Hawaii's families are appropriately vaccinated against vaccine-preventable diseases. HIC focuses on education and outreach to the general pubic and with providers.

Ongoing infrastructure building activities focused on strengthening collaboration with public and private partners to improve data collection for assessment and assure accessibility and utilization of immunization services for children and their families. Title V's participation with HIP and the Hawaii Immunization Coalition are examples of collaborations that collect/review data for assessment and plan population-based initiatives to increase immunization rates.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide immunizations for the under- and uninsured children at statewide clinics.	X			
2. Contract to provide immunizations to the uninsured children at community health centers.	X			
3. Provide referral and follow-up on immunizations for low income mothers through MCH programs.		X		
4. Provide education and outreach to at risk families of young children at community health centers.		X		
5. Send out immunization reminder notices to parents of children born in Hawai‘i under 1 year old.			X	
6. Provide education and outreach to promote immunization awareness.			X	
7. Support collaboration among agencies/programs to improve child immunization rates.				X
8. Develop policy to support increased immunizations among children.				X
9. Monitor immunization rates.				X
10. Conduct research to identify barriers to higher immunization coverage levels.				X

b. Current Activities

Infrastructure building continues with the DOH Advisory Committee on Infant Immunization. The Committee was formed in 2002 as a result of a statewide summit on child immunization. To generate more detailed immunization data, the Committee recommended conducting a retrospective study of kindergarten immunization rates

The DOH HIP is in the final stages of analyzing data from a retrospective assessment of all kindergarteners entering school (private and public) in the school year 2002-2003. School entry health records and immunizations were assessed retrospectively at ages 24 and 36 months. The results should help delineate patterns of under-immunization by location (using census block groups) and by socio-demographic characteristics.

Another research project, the In Focus program conducted through the University of Hawaii's School of Nursing, was completed to identify barriers that prevent children from receiving immunizations. Focus groups were conducted at community health centers. The 2 primary barriers were: 1) clinic hours were not convenient (not open after normal business hours) and

2) parents used regular clinic appointments to update children's immunization shots. Thus, parents were incurring a long wait time for a relatively quick service. In response to these barriers, a "free walk-in shot" clinic was piloted at one of the health centers. The clinic serves children from ages 6 months to 21 years and is open for two evenings and Saturday morning. The continuation of the successful pilot clinic and expansion to other sites remains uncertain without dedicated funding.

HIP continues to participate in AFIX, a nationally recognized quality assurance approach to improve vaccination coverage levels in provider offices. HIP reviews selected providers' charts and the Public Health Nursing Immunization Clinics. The program provides assessment and feedback to providers on their coverage levels and identifies areas to improve pratice. The Program has developed school entry requirement and general immunization posters in ten languages, as well as a media educational campaign on infant immunizations.

Copies of the multi-language read-to-me immunization coloring book developed in 2002, continues to be disseminated statewide with other informational materials to various parent groups, primary care health centers, public health nursing offices, preschools, community groups and health fairs. This coloring book was reprinted in FY 2004 with updated information on obtaining medical insurance. Crayons for the coloring books are supplied by Hawaii Covering Kids.

The Hawaii Chapter of the American Academy of Pediatrics and the EPSDT Advisory Committee participate as members of the provider network to promote immunization compliance.

Funding from HIP was used by Title V to conduct a review of service providers to improve coverage levels of children served. A report was completed and shared with HIP.

c. Plan for the Coming Year

Although, the HP 2010 objective was met for the first time this year, objectives will not be revised at this time until there is clearly a trend of continued improvement. Currently, objectives are set to meet the Healthy People 2010 objective of 80% in the year 2010.

Despite budgetary constraints and concerns about HIPAA regulations, HIP will be pursuing the development of an immunization information system (similar to an immunization registry) to improve tracking and identification of children who are out of compliance.

The services described in previous years will continue to be supported by Title V. Covering Kids, a Robert Wood Johnson grant. Program efforts will continue to provide enabling services targeting disparate families including immigrants, Native Hawaiians, and Pacific Islanders. Title V will continue to support Covering Kids through participation in the Advisory Task Force as well as its subcommittees.

All Title V programs, including primary care purchase-of-service contracts, Healthy Start, and WIC, will continue to provide education, referral and follow-up for immunizations. Program data on immunization coverage will be reviewed and monitored from these contracts and programs. Technical assistance will continue to be provided to early childhood programs within the Maternal and Child Health Branch (MCHB).

As part of its population-based services, Title V staff, as a member of the Hawaii Immunization Coalition's Infant Team, will continue to meet regularly to plan outreach and provide information for education of health professionals, community agencies, and DOH MCH Branch programs and partners. Title V staff will work together with the DOH Hawaii Immunization Program and the Advisory Committee on Infant Immunization to explore reasons for the lack of significant

improvement in immunization rates. Plans/strategies will be devised based on findings.

Infrastructure building activities will focus on reviewing the results from the provider-based assessment and kindergarten retrospective study. These studies will provide detailed local data to help target interventions and develop more effective programs.

The feasibility of linking vital statistics and insurance data will be considered to develop a cohort profile of infants and their mothers who may not have insurance coverage and whether immunizations were acquired. Data sharing agreements between DOH Vital Statistics and Hawaii's two largest insurance providers (HMSA and Kaiser Permanente) would need to be negotiated.

Other data sets to be explored are the Health Plan Employer Data and Information Set (HEDIS) immunization coverage data for managed care health plans (including Medicaid), FHSD program and contract data, and immunization records for licensed day care facilities.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	25	24.5	24	23.5	23
Annual Indicator	22.7	20.4	17.7	18.8	18.5
Numerator	542	480	414	444	440
Denominator	23882	23494	23368	23645	23795
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	22.5	22	21.5	21.3	20.8

Notes - 2002

Data is for resident population and is by calendar year. Data for the year 2001 was revised with an updated birth data file. Data for the year 2002 is based on a provisional birth data file.

The annual population estimates produced by the U.S. Census Bureau are usually used in reporting population based data for the State of Hawaii. However, due to the unexpected delays in the releasing of the age-sex population estimates for the years 2001 and 2002, the DOH/FHSD population estimation was utilized.

The measure will be updated with the population estimate data if and when it becomes available

Notes - 2003

Data is for resident population and is by calendar year. Data for the year 2002 was revised with an updated birth data file. Data for the year 2003 is based on a provisional birth data file.

The indicator data for 2001 and 2002 was updated with the U.S. Census Bureau's age-sex population estimates which were not yet released at the time of last year's application report.

The annual population estimates produced by the U.S. Census Bureau are usually used in reporting population based data for the State of Hawai'i. However, due to the unexpected delays in the releasing of the state age-sex population estimates for the year 2003, the DOH/FHSD population estimation was utilized.

Notes - 2004

Data is for resident population and is by calendar year. Data for the year 2003 was revised with an updated birth data file (numerator). Data for the year 2004 is based on a provisional birth data file.

The indicator data (denominator) for 2001-2003 was updated with the U.S. Census Bureau's age-sex population estimates released on March 10, 2005. The 2004 indicator data uses the same source.

a. Last Year's Accomplishments

Preliminary 2004 data indicate a rate of 18.5 live births per 1,000 teenagers aged 15-17. The objective of 23 was met. Although the rate decreased slightly, the difference is not statistically significant. Relative to national standards, Hawaii compares well. In 2002 (latest available national data) the U.S. birth rate for 15-17 year olds was 23.2 compared to 17.7 for Hawaii.

Title V's efforts to reduce teen pregnancy were conducted in partnership with state and community agencies. Title V coordinated planning efforts to use Temporary Assistance to Needy Families (TANF) funding for teen pregnancy prevention. Partners included: Department of Human Services (DHS), Department of Education (DOE), University of Hawaii (UH), College of Education, and teen pregnancy prevention programs. Title V now administers funding for prevention programs that include training for teachers and educational outreach.

Education/outreach in the public middle and high schools continued using an evidence-based program that provides students with teen pregnancy and STD/HIV prevention information, and social skills development. The DOE Peer Education Program also provided prevention information in 15 schools. Kapiolani Medical Center for Women and Children, Teen Intervention Program's (TIP), Parent and Children Education (PACE) teen pregnancy prevention program provided a Puppet Show for 5th and 6th graders, with homework about sexual activity for their parents in order to improve communication in families.

The Kalihi-Palama Community Health Center's Teen Theatre Group play, It Can Happen to You, which portrays the realities of unsafe sexual behavior was performed in schools statewide. It was supported with funds from DOH's STD/HIV Program, Title X Family Planning Program (FPP), and the Tobacco Cessation Program. Community activities were sponsored by the Hawaii Teen Pregnancy, Prevention and Parenting Council (HTPPPC) during teen pregnancy prevention month. See SPM 5 for Coordinated School Health Program (CSHP) educational activities and surveillance efforts to monitor sexual risk behaviors. See SPM 8 for sexual assault education and intervention efforts.

The Boys and Girls Club of Hawaii was contracted to provide an Abstinence Only Education Program (AOEP) for children ages 10 to 12. The Club uses the Smart Moves curriculum, a healthy youth development approach to build self-esteem so youth can make healthy life decisions. The program utilizes staff, peer mentors, parents/significant adults, and the community.

FPP continued to offer confidential family planning services for adolescents and provide community health education statewide, with neighbor island DOH staff increasing the availability of health services. Provider training focused on men's reproductive health needs and engaged them as preventive care consumers.

Legislation was passed in 2003 and administrative rules were adopted in December 2004 to allow pharmacists to dispense Emergency Contraception.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide teen pregnancy prevention education to students and communities.	X		X	X
2. Coordinate community planning efforts to prevent teen pregnancy.				X
3. Support inter-agency collaboration and networking to prevent teen pregnancy.				X
4. Plan and administer Temporary Assistance to Needy Families funds for teen pregnancy prevention.				X
5. Contract for Abstinence Only Education Program to selected at-risk communities		X	X	X
6. Contract for family planning educational outreach and clinical services.	X	X	X	X
7. Improve inter-agency collaboration to build infrastructure needed to support and sustain the Coordinated School Health Program.				X
8. Improve surveillance systems through inter-agency planning efforts to administer 4 school health surveys that collect student health data used for program planning.				X
9. Expand teen pregnancy prevention efforts to include non-school hour programs based on healthy youth development strategies.		X	X	X
10.				

b. Current Activities

Population-based education efforts continue, such as the Kalihi-Palama Community Health Center's play, It Can Happen to You. HTPPPC sponsored a student contest, in which the winning slogan was used to promote statewide activities during teen pregnancy prevention month: "Keep it zipped…if you're not equipped! Use Condoms."

Infrastructure-building activities include negotiating a new three-year DOH/DHS Memorandum of Agreement to support teen pregnancy prevention using TANF funding. Programs include a Summer Institute for teachers on sexuality education and continued implementation of the TIP's PACE Puppet Show for Oahu and Hawaii 5th and 6th graders and their parents. Title V also ensures all TANF-funded programs are independently evaluated to demonstrate effectiveness. A Children and Youth Specialist, within the Adolescent Wellness Program, has been hired and currently provides technical assistance and oversight of TANF contracts and activities.

Boys and Girls Club of Hawaii continues to provide Title V Abstinence Only Education Program (AOEP) for children ages 10 to 12. Another federal abstinence education award made to Catholic Charities Family Services (CCFS), targets a school program for 12 to 18 year old youth to prevent teenage pregnancy and premarital sexual activity. The Title V AOEP approach differs by promoting life skills and serving at-risk youth in community-based settings.

Using Title X funding, FPP continues to assure confidential family planning services for adolescents statewide. FPP trainings focus on preventing and managing sexual coercion and abuse. The training includes adolescent counseling approaches and a review of current Hawaii laws pertaining to adolescent services and mandatory reporting requirements. Title X funding supports the Waikiki Health Center's Youth Outreach Program with educational counseling to male clients, including incarcerated youth, and those attending alternative schools for youth at-risk.

The HTPPPC successfully planned teen pregnancy month with a slogan/art contest, teenlinehawaii.com website and quiz, radio promotions, and the Governor's Proclamation. The overall theme for the month was "Live your life before you make one." In a new partnership, health insurance provider, Aloha Care, provided TIP with support for its statewide programs.

As part of the Title V 5-year needs assessment, teen pregnancy was identified as one of the top 10 priorities, particularly for neighbor islands that have higher rates than Oahu. However, many stakeholders thought there was overlap with unintended pregnancy; thus, that issue will be included as part of the unintended pregnancy MCH priority.

c. Plan for the Coming Year

The FY 2004 indicator is still provisional, awaiting the final birth data and the release of 2005 U.S. Census population estimates for the denominator. Preliminary data for 2003 were updated.

Hawaii objectives have been set to reduce teen births by .5 percent each year. The related Healthy People 2010 goal for this measure is to reduce pregnancies among females aged 15-17 years to no more than 46 per 1,000 females aged 15-17. Hawaii has exceeded the objective. In 2004 (the latest available Hawaii data), there were 31.6 pregnancies per 1,000 females aged 15-17 years.

Ongoing direct, enabling, population based and infrastructure programs described earlier will continue to offer services through FY 2005. This includes Neighbor Island programs, such as Title V funded Malama Kauai offering pregnancy testing, counseling and referral services to teens at the Kauai Community College Wellness Center and DOH District Health Office. Kauai DOH also works with teen Drug Court clients on family planning and STD education. See SPM 05 for continued health education and related CSHP activities. See SPM 08 for public education and intervention services provided by sex assault agencies and the schools.

With some increase in funding, the Title V Abstinence Only Education Program (AOEP) will continue services. AOEP will also sponsor community events to promote the abstinence-only message. Title X is developing training and assessing resources to integrate HIV testing and counseling into family planning visits. Emergency Contraception actions are discussed in SPM 11 on unintended pregnancy, and all related efforts would also target the teen population.

TANF teen pregnancy prevention training programs will continue during this timeframe. The TIP PACE Program was expanded to reach all counties and has received the award for another two-year period.

Part of the statewide effort to combat drug use in the state includes major support of prevention programs targeted at adolescents during non-school hours. The Governor's administration plans to use TANF resources to begin non-school hour programs at 8 public schools to promote healthy youth development and prevent teen pregnancy. Implementation of the program which began in FY 2005 will be expanded.

The CSHP will conduct several HIV/STD prevention activities, including gathering qualitative data on school prevention efforts and providing training on HIV/STD prevention for health education teachers and youth to support healthy sexual behavior (abstinence and contraceptive use). Title V supports these CSHP sexual health programs through teen pregnancy prevention teacher and student training contracts using TANF funding.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	22	23	24	25	26
Annual Indicator	22.3	21.0	21.0	21.2	24.1
Numerator	856	742	742	533	725
Denominator	3836	3541	3541	2517	3009
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	25	25	26	26	27

Notes - 2002

Data for FY 2002 was not available at the time of this report, it is not known when the data will be available.

Notes - 2003

There is no data available for the year 2002. Data for 2003 was collected, but the analysis of the data is not available at this time. The form will be updated when the data becomes available.

Notes - 2004

Data is from the Department of Health Dental Health Division (DHD) which conducts the child oral health surveillance program. Oral examinations are conducted by DHD dental hygienists in public elementary schools in accordance with accepted dental epidemiology standards.

Objectives were revised based on the FY 2004 data.

a. Last Year's Accomplishments

The data for this measure comes from the State Department of Health's (DOH) Dental Health Division (DHD). For the 2004 school year, the indicator is 24.1, and does not meet the objective of 26.

The major stakeholders (private and public) are acutely aware that Hawaii 's children have one of the highest rates of poor oral health in the nation despite relatively high dental insurance

coverage, and strive to work together to improve the oral health of children in Hawaii.

The Hawaiian Islands Oral Health Task Force was successful in securing passage of legislation regarding licensure of dentists. The bill allows issuance of a special community service dental license for U.S. trained dentists or hygienists licensed in other states to practice in Hawaii if they work in an underserved area at a Federally Qualified Health Center or Native Hawaiian Health Center. The intent is to increase the pool of qualified dental care providers to work in nonprofit health centers that serve the low-income and uninsured.

Neighbor island issues were addressed through the Tri-County Group. The dental coalitions on the neighbor islands have been strong and active advocates for improving children's oral health. This group, representing each of the neighbor island counties, met to develop consensus and formulate plans to address oral health care needs which including a shortage of dental providers treating the underserved, lack of available pediatric dentists, and a large uninsured population.

Statewide, DHD remains a lead agency in children's oral health data. DHD conducts the child oral health surveillance program, which compiles statewide data on children's oral health in accordance with accepted dental epidemiology standards. Also DHD's dental hygienists continue to conduct oral screenings and education in various public elementary schools, administer fluoride rinse programs to participating Department of Education (DOE) schools and follow-up in cases where serious oral health problems are identified. DHD also provides information resources, training and technical assistance to numerous MCH programs including WIC. WIC programs educate their clientele on baby bottle tooth decay prevention and the importance of the dental home and regular care.

Community-based safety net providers through state-funded primary care contracts, provide limited dental services on-site for the under and uninsured population. This allows community health centers to provide more comprehensive care for this population.

With funding from the Maui County Council, Maui Community College developed a Dental Assistance training program, with a training site that offers low cost dental services to the community and provides valuable training experience for students. This Program achieved national accreditation from the American Dental Association in October.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide oral screenings, education and provides follow-up in serious cases in elementary schools.	X	X	X	X
2. Administer fluoride rinse programs in public schools.	X			
3. Collect, analyze and publish oral health data on children.				X
4. Provide funding for dental services to the under- and uninsured through community health centers.		X		
5. Provide oral health education to WIC low income pregnant women and young mothers.		X		
6. Mobilize statewide task force to implement Oral Health Action Plan.				X
7. Support Neighbor Island oral health community coalitions to plan and conduct activities/programs.				X
8. Use Hawaii data on children’s oral health to complete needs				

assessment and an action plan in collaboration with state/community partners.				X
9.				
10.				

b. Current Activities

The Hawaiian Islands Oral Health Task Force Strategic Plan, which incorporates the "2, 4, 6 Action Plan. The First Steps," will be finalized this year. The members narrowed the many oral health issues to the following: 1) the need for assurance of oral health care, and 2) the need for oral disease prevention and education. Members of the Task Force will continue to develop steps toward the implementation of the plan. The counties continue to meet separately to address the needs of their communities while assuring that the content areas and objectives mirror the Task Force's plan.

Statewide, the Medicaid-QUEST program provides dental services through a fee-for-service system that includes a strong case management component for those who have difficulty accessing dental services.

The Community Clinic of Maui (CCM) provides dental care for pregnant women through a Memorandum of Agreement with the Maui Oral Health Initiative. CCM is applying for a grant to fund a dental clinic on site. Hui No Ke Ola Pono provides preventive education, assessment and sealants to two elementary school second graders and the Head Start/Early Head Start Programs. This program also has a dentist and a hygienist on staff, and will soon have a pediatric dentist quarterly who can perform oral surgery at the hospital as of July. The Oral Health Institute of the Pacific, which was able to offer services for all ages including the disabled and served as the educational site for the college dental assistant program, is no longer in service due to lack of funding. Their dentist is exploring sources of funding to reopen the clinic. Maui Dental Alliance continues to meet regularly.

Head Start Hawaii has developed their oral health strategic plan encompassing four priorities: 1) oral health education for Head Start and their community; 2) prevention (including Fluoride as well as other preventive strategies); 3) increase access to resources and information for users; and 4) increase access to urban and rural providers through system, profession and Head Start program changes.

Due to the requirements of "No Child Left Behind," DHD has encountered school time constraint barriers in accessing high-risk schools. They are in the process of developing a dental health curriculum to meet the school health standards so that dental education can be integrated into the health curriculum.

As part of the Title V five-year needs assessment, oral health was found to be a continuing priority need that has not seen sufficient progress over the past 4 years since the last needs assessment was completed. Broad stakeholder input is currently being compiled for problem analysis and strategy design for this priority area.

c. Plan for the Coming Year

Title V will work with the DOH Dental Health Division to acquire current data for this measure and other child oral health indicators in conjunction with the MCH needs assessment. Based on the past 6 years of data, the objectives for this measure were revised to reflect more achievable progress.

Title V will support the recommendations of the Hawaiian Islands Oral Health Task Force and assist in moving it forward. In addition, efforts will continue to support the safety-net providers

to expand their dental capabilities to provide direct services to the under- and uninsured, especially in areas that are underserved.

Title V recognizes that good oral health for children begins with pregnant women and women of childbearing age. Efforts will be made to have oral health education included in all population-based programs for perinatal clients and advocate for dental care to be included in all health insurance coverage for pregnant women.

Title V also recognizes the serious oral health care challenge for Hawaii 's children. Plans are to build on existing infrastructure services by focusing on the utilization of the existing oral health resources, with emphasis on the dental home. Title V staff will continue to collaborate with DHD, the dental providers, pediatricians, and community programs serving young families to ensure that each child, including those with special needs, has an appropriate dental home and is accessing routine care. The proper use, placement and monitoring of dental sealants would be one important aspect of this preventive, routine dental care.

Continuing collaboration among primary care and dental providers is the primary focus to improve the dental health of children in Hawaii. Moreover, most dental insurance plans in Hawaii cover sealant placement and the number of children with insurance is relatively high. The DHD will continue with their screenings, fluoride rinse and education programs in various schools. Travel funding for DHD staff to screen neighbor island children is provided by Title V.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	4	4	3	3	2
Annual Indicator	1.4	1.8	2.2	2.2	2.2
Numerator	10	13	16	16	16
Denominator	734930	739516	742141	743848	743848
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	3	3	2	2	1

Notes - 2002

Data is for resident population and is by calendar year. Data for the year 2001 was revised with an updated death data file. Data for the year 2002 is based on a provisional death data file.

The annual population estimates produced by the U.S. Census Bureau are usually used in reporting population based data for the State of Hawaii. However, due to the unexpected

delays in the releasing of the age-sex population estimates for the years 2001 and 2002, the DOH/FHSD population estimation was utilized.

The measure will be updated with the population estimate data if and when it becomes available

Notes - 2003

Data is for resident population and is by calendar year. Due to the small number of motor vehicle deaths, a three-year annual average is being reported.

Data for the CY 2002 was revised with an updated death data file. Data for the CY 2003 is based on a provisional death data file. The indicator data for CY 2001 and CY 2002 was updated with the U.S. Census Bureau's age-sex population estimates which were not yet released at the time of last year's application report.

The annual population estimates produced by the U.S. Census Bureau are usually used in reporting population based data for the State of Hawai‘i. However, due to the unexpected delays in the releasing of the state age-sex population estimates for the CY 2003, the DOH/FHSD population estimation was utilized.

Notes - 2004

Due to small number of motor vehicle deaths, data for FY 2000-2003 has been revised reporting a three-year annual average. The FY 2004 data is using FY 2003 data since the 3 year average cannot be calculated until 2005 data is available. Data is provisional for FY 2003 & 2004. FY 2003 will be updated in next year’s report.

The reported data maybe too small to calculate reliable measures. Unstable measures are not useful in making decisions. Caution should be exercised in the analysis of the reported data.

Data is for resident population and is by calendar year. Data for the year 2004 is based on a provisional death data file. Denominator data for 2001-2004 is from the U.S. Census Bureau’s age-sex population estimates released on March 10, 2005.

Objectives for this measure were revised based on the new 3 year averages with an incremental decline every 2 years of 1%. The objectives were based on FY 2002, the first year of final data.

a. Last Year's Accomplishments

Three-year averages are used to calculate the indicator for this measure because the number of deaths is so small and varies substantially from year to year. The 2003 indicator of 2.2 is used for 2004 since the 3 year average cannot be calculated until 2005 data is available. The objective was not met. However, the numbers for this measure remain low.

Hawaii has been progressive in passing child passenger safety legislation. Currently, Hawaii law requires safety seats for children under 4 years of age and seat belts for children in the back seats of vehicles. Children under 12 are prohibited from riding in a truck bed and parents are required to attend a special class if they are caught violating the child safety seat law. Efforts have failed to pass legislation requiring children between the ages of 4-8 years and under 80 pounds to be placed in a safety seat or booster seat when riding in an automobile.

The DOH Injury Prevention and Control Program (IPCP) is leading the effort to promote and assure proper use of child car seats and has a coordinator dedicated to these issues. Child safety seat training and check-up sites are being integrated into primary care health centers, medical care facilities, county fire stations, military bases, WIC clinics, and car dealerships throughout the state. Statewide technician and instructor training continues regularly. A 32-hour National Highway Traffic Safety Administration (NHTSA) training course for certification of car

seat technicians was held, along with refresher courses.

Title V partnered with the Keiki Injury Prevention Coalition (KIPC), IPCP, and the State Department of Transportation's Safe Community Program to disseminate information and education on injury prevention issues through an extensive network of community organizations including many of the Title V agency's purchase-of service contracted providers.

Enforcement of the State's mandatory seat belt and child safety seat laws through the "Click It or Ticket" campaign continues yearly. During the 2 week program, police conduct a major public awareness campaign on the state's mandatory passenger restraint laws in conjunction with aggressive enforcement, stopping motorists on the move and at special roadblocks.

A permanent safety seat inspection station remains at Kapiolani Medical Center for Women and Children (KMC) for children with special health care needs, and includes assessments and fittings based on referrals, implementation of seat loaner program, and provision of appropriate resources (i.e., health insurance).

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collect data/information on child injury and death, child passenger safety compliance to use for policy development and planning.				X
2. Conduct educational outreach on child passenger and pedestrian safety.			X	
3. Enforce seat belt and child safety laws through “Click It or Ticket” program.				X
4. Conduct safety seat checks through an extensive network of permanent sites and at special events.		X	X	
5. Conduct training for safety seat inspection/installation technicians and instructors.				X
6. Conduct safety seat inspection and loaner program for children with special needs.		X		
7. Identify prevention strategies by reviewing information surrounding child deaths.				X
8. Assure quality of car seat inspection stations by developing a quality management protocols.				X
9. Support state and community injury prevention coalitions.				X
10.				

b. Current Activities

Efforts to promote and assure correct use of child car seats continued. IPCP developed a quality management protocol and manual for all safety seat inspection stations to assure standards of service are maintained. As part of the quality management system, the IPCP Traffic Safety and Child Passenger Safety Program Coordinators conducted site visits to all inspection stations.

The Keiki Car Seat Hotline Information and Referral phone service is no longer available through the IPCP due to lack of funding. However, arrangements are being made for information to be given through the ParentLine, the free statewide phone line which offers

support and information on various parenting concerns.

The Child Death Review (CDR) system has identified risk factors in its review of motor vehicle deaths from 1997-2000. These are in order of occurrence: seatbelt or safety restraint not used and pedestrian or non-traffic (e.g., driveway, parking lot, crosswalk, sidewalk) deaths involving lack of supervision, recklessness or speeding. This information will assist Title V, IPCP and various public and private partners with identifying prevention strategies for these types of child deaths.

The annual Child Restraint Use Survey reported the child safety seat compliance rate for infants throughout the state climbed from 72.5% in 2003 compared to 87.5% in 2004. [Kauai County achieved a perfect 100% compliance rate for infants.] The child safety seat compliance rate for toddlers jumped from 62.2% in 2003 to 82.5% in 2004. Use of seat belts for children in the back seat also improved over last year from 78.1% to 88.4%. Despite this success, Hawaii continues to lag behind the national average of 94% (2002). The survey was conducted at 15 shopping malls throughout the state. Cars containing infants and toddlers were visually inspected for child seat use.

A survey sponsored by KIPC, KMC and IPCP was conducted for all bus companies contracted by the Department of Education (DOE) that provide transportation for children with special health needs. The survey provided data on the types of safety measures provided during transport. The report identified several areas for safety improvements. Recommendations focus on changes in DOE policies, the contractual process, and training of bus company personnel. Training by KMC was also provided to DOE rehab staff and to any staff working with children with special needs on Oahu, Kauai, Maui and Hawaii.

The police from the four counties conducted the annual "Click It or Ticket" car restraint enforcement campaign. The use of an aggressive media campaign warns drivers this year about the $92 fine and the potential for death and serious injury.

Efforts to expand child restraint laws failed again this year despite increased public concern over traffic related deaths. If passed, the legislation would have required children between the ages of 4-8 years, and under 80 pounds to be placed in a safety seat or booster seat when riding in an automobile.

c. Plan for the Coming Year

Objectives for this measure were revised based on the new 3 year averages with an incremental decline every 2 years of 1%. The objectives were based on FY 2002, the first year of final data.

Ongoing activities for safety car seat use will be expanded as IPCP explores different ways to integrate child safety seat training into existing community service programs for families with young children. They will continue to provide trainings to fit children with special health care needs with safety seats. A network of inspection stations will be developed with the purpose of sharing information, addressing common issues, and securing future funding to expand efforts.

Ongoing efforts to update the DOE bus transportation policies for the special needs population will continue. Plans are to update current policies and procedures and develop and implement appropriate trainings if needed.

Efforts to promote compliance with existing child passenger safety laws will continue to be discussed by safety advocates. Title V will continue to support DOH Injury Prevention & Control Program (IPCP) and the Department of Transportation (DOT) in their legislative activities to promote passenger safety. IPCP intends to pursue the booster seat requirement in future

legislative sessions after addressing the concerns raised by the community.

The Child Death Review system continues to research the causes and circumstances of child motor vehicle and pedestrian deaths. The multidisciplinary CDR teams will focus on working with key stakeholders to identify effective prevention strategies.

The State Department of Transportation (DOT) will continue to monitor child protective safety compliance through its annual surveys. The DOT anticipates it will continue to receive Federal Transportation funds to conduct the successful Click It or Ticket car restraint enforcement campaign.

Child passenger safety information will continue to be included in the broader spectrum of injury prevention, and educational resources are available to purchase-of-service contract providers, and programs supported by Title V personnel. Identification of common errors in car seat installation is another primary prevention media activity being planned collaboratively.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	75	81	82.6	84.3	85.9
Annual Indicator	79.9	78.4	79.5	80.4	84.5
Numerator	14103	13426	14029	14546	14448
Denominator	17653	17129	17636	18095	17097
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	86.5	88.5	90.5	92.5	94.5

Notes - 2002

The Healthy People 2010 objective has been met by the State's MCH agency. A new array of annual performance objectives have been constructed for this measure. The new annual performance objectives call for a two percent (2%) annual increase based on the FY 2000 indicator. Data is by calendar year.

Notes - 2003

Data is by calendar year. The Healthy People 2010 objective has been met by the State’s MCH agency. A new array of annual performance objectives were constructed for this measure. Based on the FY 2000 indicator, an annual performance objective of a 2 percent (2%) increase has been blueprinted for this measure.

Notes - 2004

Data is by calendar year. The Healthy People 2010 objective (75%) has been met by the State's MCH agency. A new array of annual performance objectives were developed for this measure. Based on the FY 2004 indicator the objectives have been revised to show a moderate increase annually. FY 2004 data excludes babies NPO and with no information to explain the increase.

The 2003 National Immunization Survey (www.cdc.gov/breastfeeding/NIS_data/state.htm) by the Centers for Disease Control (CDC) found that Hawaii was one of few states nationally to meet all three 2010 breastfeeding objectives. Only 14 states achieved the national objective for 75% of mothers initiating breastfeeding with Hawaii scoring a rate of 80.8%. Hawaii was one of six states to achieve the second objective for 50% of mothers to breastfeed their infants at 6 months with a rate of 50.5%. Hawaii was the highest ranking state with a rate of 31% compared to the other eight states who fulfilled the third objective of 25% of mothers to breastfeed their infant till 12 months of age. This is quite an accomplishment for Hawaii.

a. Last Year's Accomplishments

Data from the Newborn Screening program indicate that 84.5% of mothers breastfed their infants at hospital discharge. The objective was not met; however, the indicator exceeds the Healthy People 2010 objective of 75%. Data from the 2003 Pregnancy Risk Assessment Monitoring System (PRAMS) reports a higher breastfeeding initiation rate of 89.3%. Although the percentage of mothers who breastfeed their infants at hospital discharge is increasing, the rate quickly declines due to the large numbers of women in Hawaii who return to work. Only 59.4% of mothers were still breastfeeding infants at 10 weeks of age (PRAMS 2003).

The Title V program promotes breastfeeding through providing enabling, population based and infrastructure activities. WIC provides comprehensive breastfeeding promotion, education and support to their pregnant and postpartum clients. Services include a breast pump loan program, an incentive program, and a nationally recognized Pumps in the School (PITS) Program. WIC maintains State and local agency level breastfeeding coordinators.

Title V perinatal support services contractors provide comprehensive breastfeeding education and support to clients. Other community-based programs that promote breastfeeding include: Pulama I Na Keiki, a statewide program focusing on Hawaiian families; Malama A Hoopili Pono-the federal Healthy Start Project on the island of Hawaii; Early Head Start and programs under the Native Hawaiian Health Systems.

Hospital delivery centers are also strong proponents of breastfeeding. Kaiser Permanente Hospital holds the prestigious designation of "Baby Friendly" hospital. Kapiolani Medical Center is currently working toward designation. The University of Hawaii, Residency Program for the second year has provided a 3 1/2 hour breastfeeding instruction for all pediatric residents and a two hour session for all obstetric residents.

All of the delivering hospitals in the state have lactation consultants or utilize the services of nurse midwives to provide support to their breastfeeding moms. The Breastfeeding Promotion Council of Hawaii (BPCH) provides leadership for the various hospital programs. The Council has a web site with information on services for breastfeeding mothers and is in the process of becoming a non-profit organization. Annually, the Council honors individuals and programs that support breastfeeding.

WIC provides information on the New Mothers Breastfeeding Act at all local agencies. The Act protects women's ability to breastfeed and express milk, encourages employers to establish policies to accommodate those activities, and protects the women's right to breastfeed in places of public accommodation.

An overview of Hawaii WIC's Breastfeeding Initiatives was published in the 2003 California

Journal of Health Promotion.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Contract to provide breastfeeding education and support to high-risk pregnant women statewide.		X	X	
2. Provide breastfeeding promotion, education and support to WIC pregnant and postpartum clients.		X	X	
3. Hospitals employ lactation consultants or nurse midwives to provide breastfeeding support to moms.		X		X
4. Provide information on breastfeeding to the public and professionals.			X	X
5. Support networking among programs and advocating for policies that support breastfeeding.				X
6. Implement actions plans related to breastfeeding promotion identified at the Perinatal Summit.				X
7. Collect breastfeeding data.				X
8. Conduct research to determine breastfeeding prevalence at 6 and 12 months.				X
9. Plan major statewide breastfeeding promotional events and campaigns.				X
10.				

b. Current Activities

WIC enabling services continues to focus on breastfeeding promotion, education and support to their pregnant and postpartum clients. The breast pump program has grown to 318 electric breast pumps that are loaned to clients as well as free manual pumps if needed.

WIC completed a randomized clinical trial to compare the breastfeeding duration rates of WIC participants who were issued an electric breast pump versus those issued a manual pump. No significant difference in breastfeeding duration was found between the two pumps.

WIC continues to provide participants with a breastfeeding incentive program. Details are listed on the web at www.hawaiiwic.com.

The nationally recognized Pumps In The Schools Program has expanded to 18 high schools.

WIC has established standardized breastfeeding policy and procedures for clinic use which were shared at the Western Region Breastfeeding Coordinators Meeting in February 2004.

Title V continued to support PRAMS to provide population based data on breastfeeding practices after birth. PRAMS and the University of Hawaii Clinical Research Center are working to conduct the Hawaii Infant Feeding Study (HIFS). The study follows up on PRAMS mothers to determine their prevalence of breastfeeding at 6 and 12 months. The overall goal of the study is to examine ethnic and geographic disparities in breastfeeding initiation, exclusivity, and duration rates, and to identify factors that enhance the likelihood of breastfeeding until 6 months of age, and beyond. Data analysis will begin in 2005.

The Healthy Mothers, Healthy Babies Coalition surveyed 54 companies to assess their

breastfeeding policies and provide information on the current breastfeeding law: 80% had experience with breastfeeding supports, 52% knew about the Act, and 87% wanted more information.

The second annual Hawaii Breastfeeding Challenge took place October 2004 at the state capitol lawn on Oahu and on Hawaii island. Hawaii ranked 2nd after Texas within the U.S. for participation.

WIC developed a breastfeeding and obesity prevention display that shows how breastfeeding reduces the risk of obesity in children by 35%. The display was used to educate legislators at the Champions for Children day.

In 2004, WIC implemented a statewide Neonatal Breastfeeding Outreach Campaign. Over 338 health professionals were surveyed to assess their knowledge and attitude about breastfeeding the premature infant. Interested agencies were provided a video entitled "A Premie Needs His Mother". Findings are being posted on the web at www.hawaiiwic.com.

Enhancements to WIC's automated computer system will be released in August 2005 to improve the quality of breastfeeding duration data reported to the CDC.

Parents And Children Together are developing a comprehensive infrastructure for the first WIC Breastfeeding Peer Counselor Project. It will graduate three breastfeeding peer counselors who will provide basic breastfeeding support for normal breastfeeding in WIC agencies.

c. Plan for the Coming Year

Since the Healthy People 2010 objective for this measure has been met, the measure objectives been revised to show a moderate increase annually. Although the percentage of mothers who breastfed their infants at hospital discharge shows a slight increase, the rate quickly declines and needs further study. Since Hawaii has a strong initiation rate, efforts must be directed to increase breastfeeding duration rates and exclusive breastfeeding.

Title V supports and recognizes the need for training of health care personnel at all levels. Title V recognizes the need for assessment to assure breastfeeding mothers have access to up to date and culturally tailored lactation services. WIC has provided a letter of support for a research project that supports this objective.

Title V recognizes that there is a need for breastfeeding support in the work place to include a breastfeeding friendly environment with private rooms, commercial grade breast pumps, milk storage arrangements, adequate breaks during the day, flexible work schedules, and onsite childcare facilities. WIC supports the development of a Back to Work Breastfeeding resource kit and legislation to assure adequate pumping breaks.

Title V encourages all hospitals to obtain the "Baby Friendly Designation". A recent internal chart review of 100 WIC records from a local hospital indicated that over 50% of pregnant women who expressed the desire to breastfeed upon admission were using formula upon discharge.

Title V supports the collection and reporting of quality breastfeeding data. In other states, breastfeeding data from the Newborn Metabolic Screening program has been used to increase hospital breastfeeding rates by sharing the data with the public. This has in turn motivated hospitals to seek technical assistance to improve their breastfeeding outcomes.

More breastfeeding research is needed like the Waianae WIC project directed by Dr. Joan Dodgson, Associate Professor of Nursing, University of Hawaii at Manoa, entitled "Exploring

Community Influences Effecting the Disparities Found in Breastfeeding Patterns on the Waianae Coast of Oahu". The project has received approval by the University of Hawaii's IRB and was funded by the Center for the Advancement of Health Disparities Research.

The Title V program staff will continue to provide comprehensive breastfeeding education and support to the high-risk pregnant women. The program will continue to support and work with the BPCH to promote breastfeeding friendly work place environments and to continue to assure that breastfeeding women are protected from discrimination.

WIC will continue/expand the PITS Program, the breastfeeding incentive program, the pump loan program and the new breastfeeding peer counselor program.

WIC also plans to pursue a breastfeeding professional position to promote breastfeeding across all Departmental programs. Plans are also in progress to celebrate National Breastfeeding Week with a press release and local TV interviews.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	98	98	98	98	98
Annual Indicator	90.9	95.3	96.8	97.8	98.0
Numerator	15985	16286	16905	17678	17878
Denominator	17588	17093	17463	18082	18246
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	98	98	98	98	98

Notes - 2003

FY 1999-2002 data for this measure has been updated. The denominators are from the updated birth records (calendar years) minus the infant deaths within one day. The numerators are from the Hawaii HI-TRACK data system of children screened at 13 of 14 hospitals. Children are screened before discharge. Recent screening data from Kaiser Permanete-Hawaii was also added. Kaiser reports summary statistics on their infant hearing data separately since they do not use HI-TRACK.

Notes - 2004

The denominator for this measure is from birth records reported minus infant deaths within one day. The numerator is the number of these infants who were screened before discharge, as reported on annual Early Hearing Detection and Intervention (EHDI) reports to the Centers for

Disease Control and Prevention. Data is reported by calendar year. Data for FY 2003 was updated. Data for FY 2004 is provisional and will be updated in next year's report.

a. Last Year's Accomplishments

The 2004 indicator was 98.0%. The objective was met. The 2004 data is preliminary and will be updated next year.

The Newborn Hearing Screening Program (NHSP) began in 1990 through a law that mandated that the DOH develop methodology to establish a statewide program for screening of infants and children age 0-3 with hearing loss. Amendment of the law in 2001 mandated screening all newborns for hearing loss and reporting screening results to the DOH.

Screening began in 2 hospitals in 1992, was provided in all birthing facilities by 1999 and is now part of standard newborn care in Hawaii. Each birthing facility has a newborn hearing screening program. 13 of 14 hospitals transfer child specific data to the state NHSP HI*TRACK data system. The 14th hospital submits aggregate data to NHSP.

Hospitals were provided bi-annual data on their newborn hearing screening performance, including percent of initial screens, missed screens, passing initial screens, and completed rescreens. This is used to identify problems, improve services, and track progress. In addition, NHSP began working with hospitals quarterly to reconcile state data against hospital delivery logs.

Newborn hearing screening, audiological assessment, and early intervention brochures are available in 9 languages. Brochures were distributed to hospitals and audiologists.

The newborn hearing-screening brochure was part of the packet sent by the Newborn Metabolic Screening Program (NBMSP) to homebirth families, until October 2003 when NBMSP could no longer obtain names of home birth parents identified through birth certificate data. According to the Deputy Attorney General's interpretation HRS, Section 338-23, the Office of Health Status Monitoring cannot provide any birth certificate data other than name, sex, and type of vital event for quality assurance or other public health purpose that is not considered "research".

NHSP assisted with follow-up for infants who need rescreening or referrals for audiological assessments. NHSP supported air transportation to O'ahu for audiological evaluations, since the necessary equipment is not available on Neighbor Islands.

In January 2002, Imua Family Services began screening Maui homebirth children. In 2003, NHSP began outreach to homebirth families statewide through midwives. Hearing screening is now available to homebirth families statewide.

Written guidelines are in place on audiological follow-up for infants who failed newborn hearing screening.

Hospital hearing screeners record risk factors for late onset hearing loss and send this information to NHSP. NHSP works with physicians to monitor the need for audiological testing.

Funding from the MCH Bureau for the Hawaii Early Childhood Hearing Detection and Intervention project supported the CSHNB/NHSP efforts to improve early hearing detection and intervention (EHDI).

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

	Pyramid Level of

Activities	Service			
	DHC	ES	PBS	IB
1. Continue newborn hearing screening at all birthing hospitals in Hawaii.	X	X	X	X
2. Assist with follow-up for rescreening, audiological assessment, or risk for late onset hearing loss.	X	X		X
3. Monitor hospital newborn hearing screening rates and assist in addressing screening barriers.				X
4. Continue home birth newborn hearing screening outreach and monitor impact on screening rates.		X		X
5. Continue software/technical assistance to birthing hospitals to facilitate reporting of screening results.				X
6. Develop database linkages to identify infants who may not have received hearing screening.				X
7. Develop/disseminate public awareness materials on early hearing detection and intervention (EHDI).				X
8. Continue education/training for hospital screening staff, audiologists, and other providers about EHDI.				X
9. Promulgate administrative rules for EHDI that are consistent with state newborn hearing screening law.				X
10. Conduct research study on causes of hearing loss in children identified through newborn screening.				X

b. Current Activities

Newborn screening continues in all birthing facilities. NHSP provides assistance with follow-up for infants who need rescreening or referrals for audiological assessments, and tracks follow-up for infants monitored for late onset hearing loss.

Confidentiality requirements are being clarified and draft administrative rules will be revised.

Updated HI*TRACK software, technical assistance and software support were provided to birthing hospitals to support efficient data reporting of newborn hearing screening results to NHSP. Alternate methods of data submission are being explored for 2 of 14 hospitals.

NHSP monitors hospital inpatient and outpatient newborn hearing screening rates and provides technical assistance to address barriers to screening, such as outdated screening equipment or lack of backup equipment. By the end of 2004, 8 of 14 hospitals had backup equipment and 2 had replaced outdated equipment. NHSP and the Newborn Metabolic Screening Program began coordinating quality assurance efforts to more efficiently identify infants who need additional follow-up due to missed screens. NHSP continues to work with hospitals and primary care providers to assure that follow-up is provided.

In 2003, NHSP began outreach to homebirth families through midwives. This continued in 2004. Hearing screening is available to homebirth families statewide.

Relevant in-service training is provided for hospital newborn hearing screening staff, audiologists, physicians and early intervention providers to improve the quality of newborn hearing screening and audiological follow-up in Hawai‘i. NHSP works closely with Hawaii's American Academy of Pediatrics-Hawaii Chapter EHDI Champion to increase awareness regarding early hearing detection and intervention.

NHSP continues to develop and disseminate public awareness materials to inform parents,

early intervention providers, physicians, and other health care professionals about universal newborn hearing screening and the importance of early intervention services for infants with hearing loss. A practitioner's manual is under development.

CSHNB received a 3-year grant from the MCH Bureau for a Baby Hearing Evaluation and Access to Resources and Services (HEARS) project to continue to improve newborn hearing screening and follow-up in Hawaii.

With funding from a cooperative agreement with Centers for Disease Control and Prevention (CDC), CSHNB is conducting a research study on causes of hearing loss in young children, as part of a multi-state study with Utah and Rhode Island. Purposes are to determine genetic and other causes of hearing loss for children identified through NHSP and to establish a model of genetic services as part of follow-up. The study includes review of the family and child's medical history, physical examination, and testing for connexin 26 and other genes. Participants are now being enrolled in the study. Geneticists from Stanford University will provide genetic evaluations.

c. Plan for the Coming Year

Newborn screening will continue in all birthing facilities. NHSP will provide assistance with follow-up for infants who need rescreening or referrals for audiological assessments, and will track follow-up for infants monitored for late onset hearing loss. NHSP will continue improving data collection and tracking procedures. NHSP will increase efforts to involve primary care providers in the follow-up process.

The lengthy process to establish administrative rules will continue.

A practitioner's manual will be completed and disseminated.

Newborn hearing screening/follow-up rates will continue to be monitored. Strategies will be developed to help additional hospitals address screening barriers, such as outdated screening equipment and lack of backup equipment. NHSP and the Newborn Metabolic Screening Program will increase the frequency of coordinated quality assurance activities to at least quarterly. NHSP will begin contacting hospitals monthly to reconcile state data against hospital delivery logs. Outreach to home birth families will continue.

NHSP will update and disseminate written guidelines on audiological follow-up for infants who failed newborn hearing screening.

Educational sessions/training will continue to be provided for hospital newborn hearing screening staff, audiologists, physicians, early intervention, and other providers.

NHSP will continue to disseminate public awareness materials to inform parents, early intervention providers, and health professionals about early hearing detection and intervention. Revised documents will be translated into 9 languages and disseminated.

The CDC/EHDI research study on causes of hearing loss in young children may continue. The cooperative agreement ends September 2005; however, an extension for an additional year will be requested to complete the study.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	3.3	4.1	3.6	3.2	2.7
Annual Indicator	4.5	3.6	2.9	2.9	2.9
Numerator	13113	10591	8344	8387	8387
Denominator	293102	294364	286800	291109	291109
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	2.3	1.8	1.4	0.9	0.5

Notes - 2002

The annual performance objectives have been modified. An annual pace has been blueprinted to achieve zero for this measure by the year 2010.

Notes - 2003

The annual performance objectives have been modified. An annual pace has been blueprinted to achieve zero for this measure by the year 2010.

Notes - 2004

Data comes from a state-wide random sample survey and is subject to sampling variability. An annual pace has been blueprinted to achieve zero disparities or this measure by the year 2010. The results of the 2004 survey is under review and not yet available.

a. Last Year's Accomplishments

The FY 2004 data for this measure shows that 2.9% of children did not have health insurance. The objective of 2.7% was not met. However, 2003 data was used for the indicator because the data from the 2004 Hawaii Health Survey was not available. Data from the 2004 survey will be available shortly. This measure is related to Healthy People 2010 Objective 1:1: increase the proportion of persons with health insurance to 100 percent.

The thrust of the Title V agency's efforts to decrease the percentage of children without health insurance are infrastructure building services, conducted in partnership with other state and community agencies.

There are two issues related to this measure, the first of which is numerator data. The Title V agency collaborates with the Department of Health, Office of Health Status Monitoring which is responsible for the annual population-based Hawaii Health Survey (HHS) to obtain numerator data. Since this is a residential telephone survey, it has limitations. For example, uninsured individuals are less likely to have a home telephone and are more likely to refuse to participate because of cultural and language barriers. Also, there has been a slow trend toward more cell phone use and cancellation of residential phone lines. The Title V agency uses the HHS data because it currently provides the best consistent estimate of uninsured children. The same module of questions related to health insurance has been asked in the HHS since 1998, providing a degree of consistency and comparability. There are small fluctuations in the data, probably due to sampling variability, small sample size and weighting of the sample. Because

of the limitations of the HHS, the Title V agency collaborated with Hawaii Covering Kids (HCK) to review various data sources to obtain a better estimate of uninsured children.

The second issue related to this measure is improved access to health insurance, which would decrease the numerator. On July 1, 2000, the Department of Human Services initiated two programs aimed at improving access for children. The SCHIP program was implemented as a Medicaid expansion and covers children up to 18 years of age with family incomes up to 200% of the federal poverty level for Hawaii. As of September 30, 2004, 13,213 were enrolled in SCHIP. The second program is a state-funded immigrant children's program targeting legal immigrants, refugees, and those born in the Marshall Islands, Federated States of Micronesia and Palau. It has the same eligibility requirements as SCHIP and as of September 30, 2004, had 2,758 enrollees.

During the reporting year, HCK and stakeholders advocated for significant changes in the QUEST eligibility process. As a result, the Medicaid agency implemented a new simplified application form for children and pregnant women and a passive renewal process. The passive renewal process allows clients to continue health coverage unless the Medicaid agency is informed of any changes in eligibility.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Development of improved methodology for measuring uninsured children.				X
2. Development and implementation of new strategies and models for outreach and enrollment.				X
3. Require Title V contractors to refer eligible uninsured children for insurance coverage.				X
4. Analysis of options for increasing coverage for children, especially those with family incomes between 200%-300% FPL.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The focus of the Title V agency's efforts for the current year, are on infrastructure building services. Collaboration continued with Hawaii Covering Kids (HCK) to obtain a better estimate of uninsured children in the state. HCK has decided to accept the rate of 7.5% for 2005, which was reported for Hawaii for the period 2002-2003 by the Georgetown University Health Policy Institute, Center for Children and Families. This report is based on the U.S. Census, Current Population Survey. The Title V agency continues to use the annual Hawaii Health Survey (HHS) as the best source of data for this performance measure for the reasons described in the preceding section of this narrative.

The Title V Director is the principal investigator on two grants to fund the Hawaii Uninsured Project (HUP) that was established to address the problem of uninsured individuals in Hawaii.

The grants were submitted by the Title V agency on behalf of a consortium of state, business, labor, health and community leaders dedicated to provide universal health insurance coverage to all residents in the state. Grant funds are contracted to the University of Hawaii and non-profit agencies for implementation. A Health Resources and Services Administration (HRSA) State Planning Grant to evaluate and identify best strategies to lower the state's uninsured rate will end this summer. A three-year demonstration grant for $3.2 million awarded by the Robert Wood Johnson Foundation is in its final year. Efforts continue to explore solutions with stakeholders and conduct economic modeling of the various options. Recommendations will be made to improve the reliability of the estimates of uninsured children. HUP has formed a committee of advocates, health care and health coverage experts, and state officials to develop and analyze potential solutions for increasing coverage for children, with an emphasis on those in families with incomes between 200% and 300% of the federal poverty level.

The Title V agency continues to work in partnership with HCK which coordinates several activities to assure that all eligible uninsured children obtain health insurance coverage. HCK local projects in Kahuku on Oahu and on the island of Kauai continue to develop innovative outreach and enrollment strategies and models that can be replicated by other communities. All Title V purchase-of-service contracts continue to require appropriate referrals for uninsured children who are eligible for health insurance coverage.

c. Plan for the Coming Year

Infrastructure building services will continue through FY 2006. In partnership with the Hawaii Covering Kids (HCK) and the Hawaii Uninsured Project (HUP), the Title V agency will reach consensus on the most valid and reliable method of obtaining numerator and denominator data for the percentage of uninsured children. This may involve two or more data sources for the numerator and may change the future objectives for this performance measure that use only the annual Hawaii Health Survey data. The objectives are currently projected with the FY 2000 indicator as the base, to result in zero in 2010.

The HUP will continue to work on improving estimates of uninsured children. Activities are currently focused on comparing data from the Current Population Survey of the U.S. Census and the Hawaii Health Survey. Strategies for increasing coverage of children will be developed, with an emphasis on those in families with incomes between 200% and 300% of the federal poverty level.

The Title V agency will continue to work in partnership with HCK and stakeholders to expand outreach and enrollment of uninsured children. All Title V purchase-of-service contracts will continue to require that eligible uninsured children be referred for appropriate health insurance coverage.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual					

Performance Objective	65	70.5	74.5	77.2	79.9
Annual Indicator	69.1	73.2	79.2	43.9	84.4
Numerator	68721	74816	82904	48526	38191
Denominator	99504	102222	104671	110459	45235
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	82.6	85.3	88	90.6	93.3

Notes - 2002

The annual performance objectives have been modified. An annual pace has been blueprinted to meet the Healthy People 2010 objective for this measure.

Notes - 2003

An annual pace has been blueprinted to meet the Healthy People 2010 objective for this measure.

Notes - 2004

The numerator is obtained from service data collected by the Department of Human Services (DHS) Medicaid program. The denominator is the sum of 1) Medicaid enrollment numbers provided by DHS and 2) numbers of uninsured Medicaid eligible children as reported by the annual Hawaii Health Survey (HHS). The denominator is made up primarily of DHS data as HHS numbers are below 4,000 children each year.
The fiscal year 2003 and 2004 data do not appear accurate when compared to fiscal year 2000-2002 data. The Title V program met with the data staff at the Medicaid agency to discuss concerns about the 2003 data. Although more accurate data was expected for 2004, data problems obviously continue. The Title V program will be meeting with higher level staff at the Medicaid agency to discuss data concerns.
An annual pace has been blueprinted to meet the Healthy People 2010 objective for this measure.

a. Last Year's Accomplishments

The FY 2004 data show that 84.4% of potentially Medicaid-eligible children received a service paid by the Medicaid program. The objective of 79.9% was met. The objectives for FY 2002 through 2010 were revised in the 2003 Title V application because improved reporting by the health plans contracted by the Medicaid agency had contributed to steady increases in this measure. Performance objectives were recalculated to result in an objective of 96% in 2010. However, fiscal year 2003 and 2004 data do not appear to be accurate, when compared to the fiscal year 2000-2002 data. Possible reasons for the discrepancies have been discussed with the Medicaid agency but the causes are not clear. The Title V agency had anticipated that such a discussion would result in more accurate data for 2004. This measure is related to the Healthy People 2010 Objective 1-4b: Increase the proportion of children and youth aged 17 years and under who have a specific source of ongoing care to 96%.

The Title V agency's efforts to increase the percent of potentially Medicaid-eligible children receiving a service paid by the Medicaid program are primarily infrastructure building services, conducted in partnership with other state and community agencies.

The numerator is obtained from service data collected by the Department of Human Services (DHS) Medicaid program. The denominator is the sum of 1) Medicaid enrollment numbers

provided by DHS and 2) numbers of uninsured Medicaid eligible children as reported by the annual Hawaii Health Survey (HHS). Data from the 2003 HHS were used in the denominator for the 2004 indicator because of a delay in receiving the 2004 HHS data. However, the discrepancy in the denominator is primarily due to the Medicaid data.

This performance measure builds on National Performance Measure (NPM) #13, which focuses on increasing insurance coverage for children and emphasizes outreach and enrollment of uninsured Medicaid-eligible children. The activities under NPM #13 affect the denominator in NPM #14. The major activities under NPM #14 affect the numerator, the number of Medicaid-eligible children who have received a service paid by the Medicaid program. These activities have focused on improving utilization of services. The Title V agency has collaborated with the EPSDT program and the health plans contracted by Med-QUEST to promote EPSDT. This information has been given to providers of care and Medicaid clients. In addition, the Title V agency's purchase-of-service contracts to community-based providers require enabling services which promote appropriate utilization of all health services, including Medicaid services. These contracts promote a system of care for vulnerable populations, which includes transportation, translation and case management services.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Improvement of Medicaid information system.				X
2. Development and implementation of strategies to improve utilization of EPSDT services.				X
3. Require Title V contractors to promote EPSDT utilization.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The focus of the Title V agency's efforts for the current year are on infrastructure building services. The same data sources will be used for this measure. However, because of the discrepancy with the Medicaid data reported in the previous section, meetings are planned with the Medicaid agency for clarification. In November 2002, the Arizona Health Care Cost Containment System (AHCCCS), the Arizona Medicaid agency, established a management information system for Hawaii Med-QUEST. In a unique state-to-state partnership, the Arizona Prepaid Medical Management Information System (PMMIS) was modified to handle records from the Hawaii Medicaid program. Hawaii is contracting with Arizona to house the system and provide needed reporting. The Hawaii PMMIS was expected to improve the quality of information produced for the Med-QUEST program. However, the issue may be that the PMMIS system does not provide the type of data needed for this Title V measure.

Last year's activities continue into the current year.

c. Plan for the Coming Year

Infrastructure building services will continue through FY 2006. The same data sources will be used for this measure. The Title V agency will collaborate with Med-QUEST to obtain more accurate data and compare the data with previous years' reports. Data will be updated in next year's report.

Last year's activities will continue into FY 2006.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	1.1	1.1	1	0.9	0.9
Annual Indicator	1.2	1.2	1.5	1.4	1.3
Numerator	212	208	266	251	238
Denominator	17519	17043	17446	18066	18233
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	0.9	0.9	0.9	0.9	0.9

Notes - 2002

Data is for resident population and is by calendar year. Data for the year 2001 was revised with an updated birth data file. Data for the year 2002 is based on a provisional birth data file. Objectives were revised to the Healthy People 2010 target.

Notes - 2003

Data is for resident population and is by calendar year. Data for the year 2002 was revised with an updated birth data file. Data for the year 2003 is based on a provisional birth data file.

An annual pace has been blueprinted to meet the Healthy People 2010 objective for this measure.

Notes - 2004

Data is for resident population and is by calendar year. Data for the year 2003 was revised with an updated birth data file. Data for the year 2004 is based on a provisional birth data file. Objectives have been set to the Healthy People 2010 objective.

a. Last Year's Accomplishments

The indicator for 2004 is 1.3%. Data is provisional. The objective was not met, although Hawaii is close to reaching the Healthy People 2010 objective of 0.9%.

Title V contracts perinatal support services (PSS) for high-risk women statewide for prenatal care, risk assessment, case management, referral and other supports. Services are also

contracted for the Baby Substance Abuse Free Environment (SAFE) program to provide outreach, early identification, and pretreatment services for substance using pregnant women.

Title V funded the Kauai Malama Project to provide case management to high-risk pregnant women.

The Malama A Ho'opili Pono Project, a federally funded Healthy Start program on Hawaii island, uses culturally supportive interventions to reduce health disparities for pregnant women and infants.

Healthy Mothers Healthy Babies (HMHB) Coalition provides education and training for stakeholders on perinatal health initiatives and also organizes advocacy efforts for perinatal issues.

MothersCare for Tomorrow's Children provides perinatal population-based services, including the Pregnancy Phoneline which provides information on perinatal resources, and referrals.

Title V partnered with community agencies to support smoking cessation initiatives and periodontal disease prevention for pregnant women, factors linked to VLBW. The DOH Tobacco Prevention Program funds perinatal provider brief intervention smoking cessation training. Maui continues smoking cessation interventions at WIC sites with an American Legacy Foundation grant targeting Hispanic pregnant and post-partum women.

Due to educational outreach efforts, perinatal providers are routinely referring pregnant women for dental care. Low cost dental services are now available for pregnant women through the community health centers and clinics like the Maui Oral Health Center.

HMHB advocated for legislation that would require Medicaid cover dental care for pregnant women, however the bill was deferred. MothersCare provided toothbrush and toothpaste incentives for pregnant women. Title V provided funding for both initiatives.

March of Dimes (MOD) sponsored eight Town Hall Meetings statewide to increase awareness about rising preterm births rates and discuss community responses. Title V staff provided pertinent perinatal data. Queens Medical Center, and health insurer, HMSA also participated.

Title V staff also presented data at the MOD Prematurity Summit. The summit was teleconferenced to medical centers statewide to address the state's increasing prematurity rate.

Title V sponsored the Annual Perinatal Summit. Dr. Milton Kotelchuk presented the latest national research and data on prematurity and low-birth weight. Title V staff presented perinatal data for Hawaii, including newly released Pregnancy Risk Assessment Monitoring System (PRAMS) results on substance use, which is a growing concern among perinatal providers.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Contract to provide perinatal support services to high-risk pregnant women statewide.	X	X	X	X
2. Contract to provide outreach and pretreatment services to substance using pregnant women.	X	X	X	X
3. Provide culturally competent services to areas of high risk for infant		X		X

mortality and morbidity.				
4. Support community development efforts to increase primary care and perinatal support services.			X	X
5. Provide training on smoking cessation and oral health education/counseling for providers of perinatal care.			X	X
6. Support efforts to improve data quality from birth certificates.				X
7. Conduct research on perinatal issues using vital statistics and other data and disseminates findings/results.				X
8. Collect, analyze, and disseminate Hawaii data from Pregnancy Risk Assessment Survey (PRAMS).				X
9. Advocate for policies that expand health service coverage to reduce poor birth outcomes.				X
10. Continue needs assessment work on perinatal health issues to improve birth outcomes.				X

b. Current Activities

Title V infrastructure building efforts continue. Organizing began for a statewide strategic planning meeting for the Hawaii Perinatal Consortium (HPC) to be held in Fall 2005. The meeting will clarify the role of the Consortium (relative to other perinatal groups) and prioritize health actions.

Title V was selected to participate in a learning collaborative sponsored by the Association of Maternal and Child Health Programs (AMCHP) and Centers for Disease Control (CDC) to address the state's increasing infant mortality rate. The project findings will used to create standards for care to improve the perinatal service system in the state.

A Title V Work Group is revising the data collection forms used by all perinatal service contractors to assure the quality of service delivery through consistent performance measurement.

The HPC Data Committee is continuing to train birth certificate registrars to improve the accuracy of data reporting with particular focus on birth weights.

Provision of enabling services to at-risk pregnant women continued through statewide PSS Providers and Baby SAFE program.

HMHB received a 2-year grant from the Hawaii Community Foundation Tobacco Control Fund to implement the Perinatal Smoking Cessation Warmline to reduce the incidence of perinatal exposure and second hand smoke to infants/children. The phoneline links providers and consumers to smoking cessation resources, information and referrals. HMHB provides brief intervention smoking cessation training to perinatal and community stakeholders.

MothersCare continues to operate the toll-free Pregnancy Phoneline and maintains an informational website, and conducts media outreach to encourage women to seek early and continuous prenatal care. A Coupons & Health Tips book offering valuable information and discounts on items useful during pregnancy is available to all pregnant women through the Phoneline.

On Maui, the American Legacy Foundation Grant continues enabling tobacco education, prevention, outreach, and referral services for Hispanic WIC clients. A Baby SAFE community worker also provides outreach, referral, and substance abuse prevention education to pregnant and post-partum mothers at Maui WIC sites.

The Malama A Ho'opili Pono Project, a federally funded Healthy Start program on Hawaii island, continues to provided culturally supportive interventions to reduce health disparities for pregnant women and infants.

As part of the 5-year needs assessment, several perinatal issues were selected as priorities related to VLBW outcomes including prenatal smoking and alcohol use and unintended pregnancy (including teen pregnancy). Input from stakeholders at a statewide meeting in October 2004 was used to begin a problem analysis for these issues. Work on the problem analysis and identification of major service interventions continues.

The Pregnancy Risk Assessment Monitoring System (PRAMS) data analysis continues to be used to examine risks for poor pregnancy outcomes including LBW.

c. Plan for the Coming Year

Objectives are set using the Healthy People 2010 target of 0.9% since the difference between the current indicator and target is minimal. Small numbers make it difficult to project real and sustained changes. Provisional 2004 data will be updated.

Findings and recommendations generated from the AMCHP/CDC sponsored Infant Mortality learning collaboration project will help to identify improvements in perinatal service delivery. The findings will also be used to set priorities for the Hawaii Perinatal Consortium (HPC) and develop a plan for further improvements in the perinatal information system.

The 2005 HPC Strategic Planning Meeting will set a framework for future actions and integration of resources to improve perinatal health outcomes, including VLBW.

PRAMS will continue to provide the State with population-based data to help with program planning and policy development for the perinatal population.

Title V in conjunction with March of Dimes (MOD) will continue to focus on reducing infant mortality and morbidity through the prevention of premature labor and low birth-weight babies.

Funding will continue for PSS providers for enabling and direct service to high-risk pregnant women. Title V PPS providers will be reporting on new performance measures, some of which relate directly to reducing VLBW.

Further training of perinatal providers will include perinatal health education on periodontal disease and the effects on birth outcomes. Brief Intervention Training and smoking cessation activities will continue.

The Malama A Ho'opili Pono Project, the federal Healthy Start project on Hawaii island, received continued federal funding through a Disparities in Perinatal Health grant. The grant will focus on transitioning the perinatal health program to community based partnerships to assure adequate local infrastructure exists to sustain services over the long-term. With a consortia of community stakeholders, the project leaders are planning a Summit in late 2005 to share lessons learned, project outcomes, and identify project directions. The program is funded through May 2009.

The HPC and other perinatal stakeholders will continue to advocate for improved systems of care for perinatal health including dental care for pregnant women, substance abuse treatment services, and early access to prenatal care. A PRAMS presentation "Dental Utilization/Education During Pregnancy" showing the data on women who are not receiving dental services or oral health education when pregnant has resulted in a Title V partnership work group which will begin meeting during 2005.

Title V needs assessment work with stakeholders will continue to finalize a problem analysis for the perinatal health priorities. The service system descriptions addressing the health priorities will continue. Information of effectiveness of existing interventions will also be compiled to identify evidence based strategies at work in Hawaii.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	5	7	6	6	5
Annual Indicator	7.3	6.8	9.0	7.9	7.9
Numerator	18	17	23	20	20
Denominator	247342	249949	254511	254726	254726
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	9	9	8	8	7

Notes - 2002

Data is for resident population and is by calendar year. Data for the year 2001 was revised with an updated death data file. Data for the year 2002 is based on a provisional death data file. Objectives were revised based on the FY 1999 indicator.

The annual population estimates produced by the U.S. Census Bureau are usually used in reporting population based data for the State of Hawaii. However, due to the unexpected delays in the releasing of the age-sex population estimates for the years 2001 and 2002, the DOH/FHSD population estimation was utilized.

The measure will be updated with the population estimate data if and when the data becomes available.

Notes - 2003

Data is for resident population and is by calendar year. Due to the small number of motor vehicle deaths, a three-year annual average is being reported.

Data for the year CY 2002 was revised with an updated death data file. Data for the CY 2003 is based on a provisional death data file. The indicator data for CY 2001 and CY 2002 was updated with the U.S. Census Bureau's age-sex population estimates which were not yet released at the time of last year's application report.

The annual population estimates produced by the U.S. Census Bureau are usually used in reporting population based data for the State of Hawai'i. However, due to the unexpected delays in the releasing of the state age-sex population estimates for the CY 2003, the DOH/FHSD population estimation was utilized

Notes - 2004

Due to small number of teen suicides, data for FY 2000-2003 has been revised reporting a three-year annual average. The FY 2004 data is using FY 2003 data since the 3-year average cannot be calculated until 2005 data is available. FY 2004 data will be updated in next year's report.

The reported data maybe too small to calculate reliable measures. Unstable measures are not useful in making decisions. Caution should be exercised in the analysis of the reported data.

Data is for resident population and is by calendar year. Data for the year 2004 is based on a provisional death data file. Denominator data for 2001-2004 is from the U.S. Census Bureau's age-sex population estimates released on March 10, 2005.

Objectives for this measure were revised based on the new 3 year averages with an incremental decline every 2 years of 1%. The objectives were based on FY 2002, the first year of final data.

a. Last Year's Accomplishments

Three-year averages are used to calculate the indicator for this measure because the numbers are small and vary substantially from year to year. The 2003 indicator of 7.9 is used for 2004 since the 3 year average cannot be calculated until 2005 data is available. The objective was not met. However, the numbers for this measure remain low.

Programs to reduce adolescent suicide follow recommendations from the National Strategy for Suicide Prevention including increasing awareness about the problem; recognizing the link to mental health and substance abuse disorders; improving health care access; and surveillance for those at risk.

See SPM 5 on teen smoking for efforts to reduce teen substance use and SPM 8 for physical fighting in the State. See narratives for PM 13 and PM 14 on efforts to increase accessibility to health care for children.

The State Departments of Health (DOH) and Education (DOE) continue to support surveillance instruments on adolescent behavior including the Youth Risk Behavioral Survey (YRBS) for High School and Middle School students. The survey includes questions on suicidal thoughts and behavior. Data from the 2003 YRBS are provided in the attached table.

Despite efforts by the interagency Adolescent Survey Committee to improve data collection for all four school health surveys, an adequate sample was not drawn to produce weighted data for the 2003 YRBS. Plans have been developed to address the problem in 2005.

The Hawaii Child Death Review Council (CDRC) continued to improve data collection and case review procedures for all child deaths including suicide. Agency council members use the information from the case reviews to identify potential program and policy changes to prevent child death.

Population based programs incorporate best practices in healthy youth development as outlined in the State Adolescent Wellness Plan, Laulima in Action. Many of these programs are school based such as the Peer Education Program (PEP) which continued to train peer mentors to reach youth through one-to-one contacts addressing topics including injury, violence, and suicide.

The Coordinated School Health Infrastructure Grant from the Centers for Disease Control supports efforts to 1) build coordination between DOE and DOH and 2) enhance capacity to promote healthy youth development at the school level. The promotion and support of healthy lifestyles impacts all aspects of teen health including social-emotional development, and suicide prevention. Regular meetings with key DOE and DOH staff have been held to improve inter-department collaboration. By September 2004, 4 School Complexes (made up of a high school and its feeder middle and elementary schools) were operational.

Suicide prevention is integrated into the new DOE health standards. Curriculum included methods to build youth resiliency, teaching strategies for at-risk youth, mental and emotional health promotion focused on loss and grief.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide suicide prevention education to students and the community.			X	
2. Improve inter-agency collaboration to build infrastructure needed to support and sustain the Coordinated School Health Program.				X
3. Develop a statewide suicide prevention plan.				X
4. Develop greater coordination and collaboration to address suicide prevention.				X
5. Identify suicide prevention strategies by reviewing information surrounding child deaths.				X
6. Provide training to promote healthy youth development and suicide prevention efforts.				X
7. Improve surveillance systems through inter-agency planning efforts to administer 4 school health surveys that collect student health data used for program planning.				X
8. Promote increased awareness and education of suicide as a health problem, remove the stigma, identify those at-risk and provide support to survivors.			X	X
9. Support continued research into evidence-based practices and secure resources to expand services.				X
10.				

b. Current Activities

The Injury Prevention and Control Program (IPCP) is the lead agency to address suicide in DOH. IPCP published the State Injury Prevention Plan developed with broad stakeholder input. Strategies to address suicide include: suicide prevention training; a public awareness campaign; continued research; and promotion of effective clinical and professional practices and polices.

A team from Hawaii, consisting of private and public agencies and including a consumer, was sponsored through the Substance Abuse and Mental Health Services Administration (SAMHSA) to attend the Suicide Prevention Resource Center (SPRC) Regional Conference. IPCP and Title V representatives participated in the conference planning and team membership. The goals of this conference were to 1) provide opportunities to share evidence-based practices and experiences with other states; 2) receive technical assistance and build

capacity for suicide prevention planning; 3) strengthen relationships between members within the team. The team formed a Suicide Prevention Steering Committee that will develop a strategic plan for suicide prevention and have identified additional stakeholders to participate in this process.

"Ending Violence: A 2004 Status Report on Violence Prevention in Hawaii" produced by the Social Science Research Institute of the University of Hawaii in collaboration with the DOH Injury Prevention and Control Program (IPCP), Prevent Violence Hawaii and MCHB was released this year. The report is a call to action and provides recommendations to address all types of violence, including suicide.

Population based services provided through the DOE PEP continued as an important student suicide prevention effort. The DOE modified the PEP program to improve school support and program effectiveness by establishing it as a full time program in 15 schools with 4 high schools offering PEP as an elective class.

The Comprehensive School Health Program Infrastructure Grant has developed a Blueprint for Action to promote health issues at the school level, including drug use and abuse and other mental health concerns. Two additional school complex sites have been added to the original 4 CHSP sites. Each complex has identified a team of school and community partners to work on the project.

HHI will fund a Summer Institute for teacher training this year focusing on prevention of school violence, including suicide.

The Family Violence Prevention Fund (FVPF) was contracted by Title V to provide technical assistance to 6 community health centers to develop violence prevention protocols. The protocols are a new requirement for many MCH Branch contracted service providers. The goal of this project is to strengthen comprehensive violence prevention and early intervention strategies.

The CDR Council is finalizing a report including suicide information from 1997 to 2000. Findings will be shared with stakeholders to increase awareness of this issue and discussion of next steps.

c. Plan for the Coming Year

Objectives for this measure were revised based on the results of using 3 year averages to calculate the annual indicator. Objectives were set using FY 2002 as a baseline (the first year of final data) with an incremental decline every 2 years of 1%.

The Suicide Prevention Steering Committee will continue work to: 1) broaden its membership; 2) develop a strategic plan; 3) explore existing evidence-based programs; and 4) identify new funding sources. A Suicide Prevention Coordinator will be hired under the IPCP.
This Steering Committee will support Maui Youth and Family Services' application to the federal SAMHSA for a grant to implement the nationally recognized Signs of Suicide (SOS) program in the Maui School District. The program has been shown to reduce suicide attempts and increase help-seeking among secondary school students. The grant will evaluate the program's effectiveness and link youth to appropriate mental health services.
The Steering Committee will actively support the efforts of community based organizations like Hawaii SPEAR (Suicide Prevention, Education, Awareness and Research) Foundation to increase awareness and education of suicide as a health problem, remove the stigma, identify those at-risk and provide support to survivors. The organization was formed by the family and friends of teens who have committed suicide. Activities include conferences, an annual walk, a website with information and links to other suicide prevention resources.

PEP will continue to offer education to youth in areas of injury, violence and sex assault. See SPM 08 for additional information on sex assault and the Building Partners for Youth Project that created a CD with resources/information on promoting partnerships for healthy youth development and non-school hour programming.

The Coordinated School Health Infrastructure Grant continues efforts to build agency coordination and capacity to promote health among students.

The Adolescent Survey Committee (ACS) is responsible for the planning, distribution and collection of the 4 health surveys to the middle and high schools. To assure an adequate sample is collected for each health survey, a statewide random sampling of approximately 2,200 students will be collected per survey during school year 2005-2006. The sample size is more manageable than those collected in 2003 which were designed to provide more detailed school level data.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	75	86.1	86.5	86.4	86.9
Annual Indicator	84.9	89.9	85.3	85.7	88.7
Numerator	180	187	227	215	211
Denominator	212	208	266	251	238
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	87.5	88	88.5	89	89.5

Notes - 2002

Data is for resident population and is by calendar year. Data for the year 2001 was revised with an updated birth data file. Data for the year 2002 is based on a provisional birth data file. There are 3 tertiary care centers in Hawaii: Kapiolani Medical Center for Women and Children, Tripler Army Medical Center and Kaiser Permanente Moanalua Medical Center. The performance objectives have been revised to achieve the Healthy People 2010 target for this measure.

Notes - 2003

Data is for resident population and is by calendar year. Data for the year 2002 was revised with an updated birth data file. Data for the year 2003 is based on a provisional birth data file.

There are 3 tertiary care centers in Hawaii: 1) Kapiolani Medical Center for Women and

Children, 2) Tripler Army Medical Center and 3) Kaiser Permanente Moanalua Medical Center.

An annual pace has been blueprinted to meet the Healthy People 2010 objective for this measure.

Notes - 2004

Data is for resident population and is by calendar year. Data for the year 2003 was revised with an updated birth data file. Data for the year 2004 is based on a provisional birth data file.

There are three medical facilities considered to be tertiary care centers in Hawaii: 1) Kapiolani Medical Center for Women and Children; 2) Tripler Army Medical Center; and, 3) Kaiser Permanente Moanalua Medical Center.

The performance measure objectives have been set to achieve the Healthy People 2010 objective in the year 2010.

a. Last Year's Accomplishments

Provisional data for 2004 indicate 88.7% of very low birth weight infants were delivered at facilities for high-risk deliveries and neonates. The objective was met. Hawaii is close to achieving the Healthy People 2010 objective of 90%.

Hawaii continues to have no formal designation of NICU by level. Based on capabilities of Level III Centers nationwide, Kapiolani Medical Center for Women and Children and Tripler Army Medical Center report themselves as Level III. Kaiser Medical Center has the capacity to handle most high-risk deliveries, caring for premature ventilated babies in their own NICU. Kaiser does not transfer mothers out to other facilities based on risk of delivering a low birth weight baby, but do not declare themselves Level III because of certain gaps in pediatric subspecialty services. For this measure, Kaiser is considered Level III.

Tertiary care centers are located only on the island of Oahu. There is limited access to specialty obstetric care on the neighbor islands and in rural Oahu for high-risk pregnant women. All high-risk deliveries are scheduled at Level III hospitals on Oahu or flown in by air ambulance in an emergency. On Lanai, pregnant women receive prenatal care from Family Practice physicians and the obstetrician flies in once a month. No deliveries occur on Lanai (except precipitous labor emergencies), births are planned for delivery on the islands of Oahu or Maui. On Molokai, certified nurse midwives provide perinatal care to pregnant women and perform low-risk vaginal deliveries on the island. An obstetrician flies to Molokai twice monthly to see patients and provide supervision to the midwives; all other births occur on Oahu or Maui. Air ambulance services for the neighbor islands are needed to fly high-risk deliveries Oahu hospitals. Funds were released to provide Maui County with air ambulance service for all 3 islands.
Title V funds perinatal support services (PSS) statewide to provide enabling services including case management and care coordination for pregnant women with high-risk factors. Services are also contracted for the Baby Substance Abuse Free Environment (SAFE) program to provide outreach, early identification, and pretreatment services for substance using pregnant women.

The Malama Program on the island of Hawaii, a federal Healthy Start initiative, works with the island's high-risk populations to identify women at risk for problem deliveries and neonates to assure access to services.

Kauai District Health Office (DHO) received Title V funds to provide support services to high-risk pregnant women through the Malama Kauai Program.

Title V was selected to participate in a learning collaborative sponsored by the Association of Maternal and Child Health Programs (AMCHP) and Centers for Disease Control (CDC) to

address the state's increasing infant mortality rate. A state team has been formed to address the issue and research has begun.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Contract to provide perinatal support services to high-risk pregnant women statewide.	X	X		X
2. Contract to provide outreach and pretreatment services to substance abusing pregnant women.	X	X		X
3. Provide culturally competent services to areas of high risk for infant mortality and morbidity.	X	X		X
4. Assure access from the neighbor islands to tertiary care centers through the air ambulance system.				X
5. Conducts research on factors contributing to infant mortality rates to improve the system of perinatal services.				X
6. Support efforts to improve coordination and collaboration among perinatal providers.				X
7. Collect, analyze, and disseminate Hawaii data from Pregnancy Risk Assessment Survey (PRAMS).				X
8. Advocate for policies which improve access to perinatal care.				X
9. Support community based efforts to improve primary care and perinatal support services.				X
10.				

b. Current Activities

With limited resources and no Level III birthing center on the neighbor islands, care coordination becomes a critical component in preventing high-risk deliveries. The Title V programs continued to fund purchase of service contracts to assure perinatal support services are available to high-risk pregnant women statewide.

The Malama Program on the island of Hawaii, federal Healthy Start initiative, continues to identify women at risk for problem deliveries and neonates providing direct health care and culturally appropriate enabling services.

The Kauai Malama Project received continued funding through Children's Trust Fund, which is administered by Title V, to provide high-risk pregnant women with perinatal support services.

The Maui District Health Office (DHO) utilizes Title V staff to coordinate perinatal services in Maui County and improve collaboration among providers. The Maui Tobacco Free Partnership and Kaiser sponsored smoking cessation training for all DOH Women Infant & Children (WIC) staff. A Baby Substance Abuse Free Environment (SAFE) outreach worker is also present at Maui WIC sites to offer counseling and pretreatment services to pregnant and post-partum women with a substance abuse problem.

Hawaii, like other states, is experiencing a shortage of OB/GYN specialists particularly on the neighbor islands. The number of doctors who deliver babies and provide care to the mother has dropped by 9% to 146 statewide in the past 2 years, according to the Hawaii chapter of the American College of Obstetricians and Gynecologists (ACOG). Moreover, 42% of Hawaii OB-

GYNs plan to quit practice, with 29% planning to stop delivering babies in the next 5 years. The majority cited the risk of lawsuits as the main reason.

Healthy Mothers Healthy Babies (HMHB) receives Title V funds to provide advocacy and training to perinatal stakeholders statewide. This past legislative session HMHB advocated and testified in support of tort reform to limit liability for obstetricians and gynecologist in malpractice lawsuits. The bill was deferred this year.

HMHB & Title V convene regular quarterly meetings of PSS providers to share data, raise common concerns, and discuss methods to improve outreach, referrals, and care coordination to assure continuous quality of care for their clients.

PRAMS data is analyzed and disseminated to increase awareness about perinatal issues and used for program decisions. Increasingly, PRAMS data is requested by agencies to assist with program assessment and evaluation. WIC uses PRAMS data to monitor continuity of breastfeeding. The Tobacco Prevention Coalition uses PRAMS smoking data to evaluate effectiveness of interventions targeted at mothers and children. HMHB tracks various perinatal risk factors to determine policy priorities.

The State Infant Mortality (SIM) Collaborative state team continues the investigative process and meets regularly to discuss data findings and determine the next course of action.

c. Plan for the Coming Year

Objectives for this measure were set to achieve the HP 2010 objective of 90% in 2010. Provisional data for 2004 will be updated.

The Title V program will continue to fund purchase-of-service contracts to assure perinatal support services are available to high-risk pregnant women statewide.

The Malama A Ho'opili Pono Project, the federal Healthy Start project on Hawaii island, received continued federal funding through a Disparities in Perinatal Health grant. The grant will focus on transitioning the perinatal health program to community based partnerships. The goal is to assure services will be sustained over the long term and be more effective at identifying and responding to community needs. With a consortia of community stakeholders, the project leaders are planning a Summit in late 2005 to share project outcomes, lessons learned, and identify project directions. The program is funded through May 2009.

HMHB & Title V continue to convene regular quarterly meetings of PSS providers to share data, raise common concerns, and discuss methods to improve quality of care for their clients.

PRAMS revised its sampling methodology to over sample Chinese and Korean women to generate ethnic-specific data for this group. Chinese and Korean women have the lowest infant mortality rate in the nation. The results will be used to compare risk factors for this group to other ethnic groups with higher rates to identify potential protective factors that can prevent/reduce infant mortality.

The SIM Collaborative state team will continue to attend meetings with other state teams and national experts to present research findings for input and discussion. The discussion will focus on using the data to promote policies and interventions in each state. High-risk delivery data will be included in part of the research presentation.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care*

beginning in the first trimester.

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	78	83.8	84.5	85.4	86
Annual Indicator	83.4	82.1	82.0	80.4	79.0
Numerator	14614	13990	14307	14522	14412
Denominator	17519	17043	17446	18066	18233
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	81	82	83	84	85

Notes - 2002

Data is for resident population and is by calendar year. Data for the year 2001 was revised with an updated birth data file. Data for the year 2002 is based on a provisional birth data file. The performance objectives have been revised to achieve the Healthy People 2010 target for this measure.

Notes - 2003

Data is for resident population and is by calendar year. Data for the year 2002 was revised with an updated birth data file. Data for the year 2003 is based on a provisional birth data file.

An annual pace has been blueprinted to meet the Healthy People 2010 objective for this measure.

Notes - 2004

Data is for resident population and is by calendar year. Data for the year 2003 was revised with an updated birth data file. Data for the year 2004 is based on a provisional birth data file.

The performance measure objectives have been revised based on the FY 2003 indicator with a 1% increase annually.

a. Last Year's Accomplishments

Provisional data for 2004 indicates 79.0% of pregnant women received early prenatal care. The objective was not met. FY 2003 data was updated to 80.4%. The difference is not statistically significant. Hawaii rates have been stable over the years and comparable to national rates. In 2002 (latest U.S. data) the Hawaii rate was 82% versus 83.7% for the U.S.

Title V funds are used to contract Perinatal Support Services (PSS) for outreach, case-management and other enabling services to ensure access to early prenatal care of high-risk pregnant women. The Hawaii Malama Program, a federal Healthy Start initiative, continued to identify cultural practices to improve pregnancy outcomes for high-risk women. Efforts include outreach to encourage early prenatal care.

Similarly, community programs like the Kauai Malama Project provided perinatal support services to high-risk pregnant women. Title V and Title X Family Planning (FP) programs collaborated and monitored PSS providers to evaluate service coordination. The time between a positive pregnancy test and an appointment for prenatal care is one of the performance measures used for evaluation.

Title V funds population-based services through MothersCare for Tomorrow's Children that provides public awareness and incentives to encourage early prenatal care. MothersCare also manages the Pregnancy Phoneline for information on statewide perinatal resources, information and referrals.

A streamlined Medicaid application process for pregnant women was implemented by the Department of Human Services during 2004 to assure determinations were received within five working days. The Department of Health evaluated the process quarterly. PSS providers confirmed the Medicaid application process has been shortened considerably. The State also provided funding for Medicaid coverage to pregnant legal immigrants to help facilitate early prenatal care.

The Pregnancy Risk Assessment Monitoring System (PRAMS) data system provided data analysis of maternal behaviors during pregnancy for Title V programs. A poster presentation titled, "Is Insurance Status A Significant Barrier To Women Accessing First Trimester Prenatal Care In Hawaii?" was displayed at the national PRAMS meeting. Results of this study showed the lack of insurance is not the only barrier to early entry into prenatal care. Most women did not seek PNC because they were unaware of their pregnancy. Women most likely to delay early prenatal care were uninsured women residing in rural areas, particularly the neighbor islands. The need for outreach to educate women about planned pregnancy and available resources was recommended. The PSS and FP programs continue to play a key role in this effort.

The Hawaii Perinatal Consortium sponsored the Annual Perinatal Summit promoting the need for a system approach to address prematurity and access to perinatal care. Dr. Milton Kotelchuck the keynote speaker addressed the need for appropriate prenatal care and access to care issues.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Contract to provide perinatal support services to high-risk pregnant women statewide.	X	X		X
2. Contract to provide outreach and pretreatment services to substance abusing pregnant women.	X	X		X
3. Provide culturally competent services to areas of high risk for infant mortality and morbidity.	X	X		
4. Provide referral services to uninsured women with positive pregnancy tests to prenatal care providers.		X		
5. Support community development efforts to increase primary care and perinatal support services.		X		X
6. Contract to provide information/outreach to promote the importance of prenatal care.		X	X	X
7. Implement action plans related to increasing access to care for				

pregnant women.				X
8. Address delays in Medicaid application processing for pregnant women.				X
9. Use data on utilization and access to perinatal services to conduct needs assessment in collaboration with state and community partners.				X
10.				

b. Current Activities

The Title V agency received a grant to form a State Infant Mortality (SIM) Collaborative, to investigate the incidence of infant mortality in the state. Areas for investigation and evaluation are: access to prenatal care, birth data quality and measuring birth outcomes across the different hospitals. The collaborative is a joint project between the Association of Maternal and Child Health Programs (AMCHP) and Centers for Disease Control (CDC).

Title V continues to fund and monitor purchase-of-service contracts for perinatal support service and access to care for high-risk pregnant women statewide. The Malama A Hoopili Pono Program on the island of Hawaii received continued funding for direct health care and enabling services integrating cultural practices for high risk pregnant women. The Kauai Malama Project received funding from the Children's Trust fund to continue perinatal support services to the high-risk pregnant women.

Title X Family Planning programs continue to work with Title V funded perinatal programs for provider referrals to prenatal care for women who have positive pregnancy tests. Title V continues to fund MothersCare for Tomorrow's Children to support population based programs promoting the importance of prenatal care.

The Title V program will continue to support the Healthy Mothers Healthy Babies Coalition to convene quarterly meetings of the PSS and Perinatal Advocacy Network (PAN) to identify perinatal issues and related educational opportunities.

The Title V program continues to distribute PRAMS data to perinatal service providers, policy makers and the public to increase awareness of perinatal issues including access to care. A PRAMS data presentation during a PAN meeting, "Dental Care During Pregnancy", showed pregnant women with dental insurance were more likely to seek dental care than those without dental insurance. As a result, Healthy Mothers Healthy Babies (HMHB), advocated for legislation this year to require Medicaid provide dental coverage for pregnant women. The legislation did not pass.

Title V formed a data workgroup to improve data assessment and collection by PSS providers.

c. Plan for the Coming Year

FY 2004 provisional data will be updated. The objectives for this measure were revised to reflect more achievable progress with a 1% increase annually based on the FY 2003 indicator (last year of final data).

Hawaii SIM Collaborative representatives will be attending a national meeting in July 2005. Representatives will report on state progress on SIM plans and analyses, share lessons learned with the larger collaborative, and receive technical assistance in developing action steps to further explore the infant mortality problem. Strategies to improve early prenatal care access will be considered.

Title V will continue to fund PSS programs and improve data quality and service delivery.

Services will continue to include outreach to high-risk pregnant women who often experience barriers in accessing early prenatal care.

The Big Island Malama A Hoopili Pono Program through the HRSA Disparities in Perinatal Health Grant will continue to evaluate the effectiveness of cultural interventions and determine whether these practices increase early entry into prenatal care. The Kauai Malama Program will be seeking continued funding to provide perinatal support services to high-risk pregnant women including community outreach to encourage early prenatal care.

HMHB will continue to provide perinatal advocacy and education to stakeholders including PSS providers. MothersCare will continue to operate the Pregnancy Phoneline and provide resources, referrals and incentives for pregnant women to enter and continue regular prenatal care.

The PRAMS Project will continue to provide data to increase understanding of pregnant women's needs including those related to access to prenatal care.

D. STATE PERFORMANCE MEASURES

State Performance Measure 3: *The percent of pregnant women who report use of alcohol, tobacco, and other drugs during pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	14.7	14.6	14.6	14.5	14.4
Annual Indicator	14.7	14.8	12.0	14.1	14.1
Numerator	2366	2472	2054	2494	2494
Denominator	16147	16739	17064	17709	17709
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	14.3	14.3	14.2	14.1	14.1

Notes - 2002

Data for the years 1996 to 1999 comes from a study conducted by the DOH Alcohol & Drug Abuse Division. From 1999 report the data for this measure come from Hawaii's Pregnancy Risk Assessment Monitoring System (PRAMS).

The DOH started its Pregnancy Risk Assessment Monitoring System (PRAMS) in June 1999. The data for SPM #03 was changed to take advantage of this newly developed data capacity.

The year 2000 was the first full operational year for Hawaii PRAMS. The 2000 data is the most

recent set of data available.

A new array of annual performance objectives have been constructed for this measure. The new annual performance objectives call for a .5 percent (0.5%) annual decrease.

Notes - 2003

Data for the years 1996 to 1999 comes from a study conducted by the DOH Alcohol & Drug Abuse Division. From 1999 report the data for this measure come from Hawaii's Pregnancy Risk Assessment Monitoring System (PRAMS).

The DOH started its Pregnancy Risk Assessment Monitoring System (PRAMS) in June 1999. The data for SPM #03 was changed to take advantage of this newly developed data capacity.

The year 2000 was the first full operational year for Hawaii PRAMS. The 2002 data is the most recent set of data available.

A new array of annual performance objectives have been constructed for this measure. An annual performance objective of a 0.5% decrease has been blueprinted for this measure.

Notes - 2004

Data for the years 1996 to 1999 comes from a study conducted by the DOH Alcohol & Drug Abuse Division. From 1999 report the data for this measure come from Hawaii's Pregnancy Risk Assessment Monitoring System (PRAMS). The DOH started its Pregnancy Risk Assessment Monitoring System (PRAMS) in June 1999. The data for SPM #03 was changed to take advantage of this newly developed data capacity. The year 2000 was the first full operational year for Hawai'i PRAMS. The 2003 data is the most recent set of data available.

A new array of annual performance objectives have been constructed for this measure. An annual performance objective of a 0.5 percent (0.5%) decrease has been blueprinted for this measure. This measure will be dropped next year and replaced by two state measures: one on prenatal alcohol use and another on prenatal smoking.

a. Last Year's Accomplishments

This measure reflects the State priority to reduce substance use. Data comes from the Pregnancy Risk Assessment Monitoring System (PRAMS), a population based survey of mothers at 2-4 months after child birth. The 2003 indicator is 14.1 (the latest available data). The objective was met. Although the rate increased slightly, the difference is not statistically significant.

The attached table compares the PRAMS data with Healthy People 2010 objectives for substance use during pregnancy. Hawaii met the HP 2010 objective for alcohol use, but not for smoking or drug use. Results for 2000-02 PRAMS are being disseminated through presentations and publications. FY 2003 is being analyzed.

Efforts continue to focus on maternal health during pregnancy. Title V funded contracts to provide perinatal support services (PSS) to high-risk women statewide. The women are assessed for psychosocial risks such as substance use and smoking. Funding also continues for the Baby S.A.F.E. (Substance Abuse Free Environment) program that provides screening, early identification, outreach, educational, and pretreatment services to substance using pregnant women. Baby S.A.F.E. programs are on Oahu, Maui, and the Big Island (2 sites). The DOH Alcohol Drug Abuse Division (ADAD) contracts with Child and Family Services to provide a Baby S.A.F.E. program on Kauai.

Healthy Mothers Healthy Babies (HMHB) received funding from the Hawaii Community Foundation's Tobacco Funds to train providers in Brief Intervention. HMHB coordinates the Hawaii Perinatal Smoking Cessation Warmline, which provides information and referral. Their

successful "Healthy and Hapai Day" for pregnant women featured a session on Smoking and Pregnancy. HMHB and the March of Dimes (MOD) sponsored a series of statewide presentations by Dr. Willie Parker on Substance Use and Pregnancy Care.

Hawaii`s increasing drug use problem has become a major policy priority over the past 2 years. Over $14 million was appropriated in 2004 for anti-drug programs. A report issued by the Governor's office identified action steps to assure progress. The report was developed with input from experts in substance use as well as extensive community input.

Over 50 organizations and medical professionals publicly appealed to the Honolulu Prosecutor to drop manslaughter charges against a drug addicted mother whose infant died 2 days after birth, arguing that prosecution would discourage pregnant drug abusers from seeking adequate care for themselves and their unborn babies. The mother pleaded no contest to a manslaughter charge and received 10 years of probation. She is currently in the process of appealing her case.

In May 2004 the S.A.F.E. Council sponsored a press conference and panel discussion to inform the public that it is counterproductive to prosecute women for using substances while pregnant. The Council sent letters and information to officials involved in the case. The S.A.F.E. Council continues to meet quarterly, or as needed.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct the Pregnancy Risk Assessment Monitoring Survey (PRAMS) to collect data on substance use during pregnancy.				X
2. Contract to provide perinatal support services to high-risk pregnant women statewide.	X	X		X
3. Contract to provide outreach and pretreatment services to substance abusing pregnant women.		X		X
4. Advocate for policies/programs that support treatment for drug-addicted mother.		X		X
5. Sponsor training on smoking cessation interventions and substance use and parenting for perinatal service providers.		X		X
6. Provide screening and referral for WIC low income perinatal clients who use substances.				X
7. Continue needs assessment work to refine problem analysis and analyze the service system with stakeholder input.		X		X
8. Support work of the Fetal Alcohol Spectrum Disorders Task Force to improve the system of services to prevent FASD.		X		
9.				
10.				

b. Current Activities

Title V continues the programs to reduce substance use among pregnant women as described previously through contracting and monitoring services for high risk women and providing population based outreach/education programs through partnerships with other agencies. . On-going services described in the previous year's narrative will continue.

WIC continues to screen and provide information on substance use to pregnant clients. WIC maintains a smoking cessation trainer on staff, who serves as a resource person for the program. Baby S.A.F.E. has a Memorandum of Agreement with WIC on Maui to provide outreach, referral, substance use prevention education to pregnant and postpartum clients.

PRAMS continues to collect data on substance use during pregnancy. FY 2003 is being analyzed and 2004 data will be reported next year.

In January 2005, the Hawaii Drug Control Plan was released by the Lt. Governor's Office. The plan builds on the 2004 report and details the goals and key strategies that will be implemented over the next 2 years. The plan focuses on prevention, treatment, and law enforcement to combat illicit drug use and underage drinking.

In February, the DOH Alcohol and Drug Abuse Division met with MCH, and various partners to develop the Strategic Prevention Framework, that will be integrated into the Drug Control Plan. This framework expands the prevention component of the Plan.

Title V was awarded a subcontract from Northrop Grumman, as an agent of the federal Substance Abuse and Mental Health Services Administration (SAMSHA), to address and build an integrated and sustainable state system for Fetal Alcohol Spectrum Disorders (FASD) prevention. Hawaii is one of 10 states selected for support. This subcontract began in November 2004 and supports the development of a needs assessment and strategic plan to increase resources in many arenas, including providing training to health and human service workers about FASD. A Task Force has been convened to work on the project comprised of community providers and consumers. A proposal has been submitted to secure additional multi-year funding for plan implementation.

The FASD Task Force met with Dan Dubovsky, FASD Specialist with the FASD Center for Excellence, for training and technical assistance. Title V with HMHB, coordinated a statewide series of 20 presentations by Mr. Dubovsky on FASD for community providers, physicians, hospital staff, state agencies and the general public.

As part of the Title V 5-year needs assessment, prenatal alcohol and tobacco use were identified as two of the top 10 health priorities. Stakeholder input was solicited through existing community coalitions and a survey conducted at the 2004 Perinatal Summit. A problem analysis was begun to identify major risk/protective factors and existing services/interventions. Stakeholder input was solicited for the problem analysis at a statewide meeting held in October 2004.

c. Plan for the Coming Year

This measure is being revised next year based on results of the Title V needs assessment. The percentage of prenatal smoking and alcohol use will be reported as 2 separate state performance measures.

The Title V program will continue to provide infrastructure building training opportunities for service providers to identify and assess substance use and to expand the capacity to treat pregnant women who are using substances. On-going services described in the previous year's narrative will continue.

The Perinatal Support Services (PPS) providers will continue to screen and provide referral/resource information for those who screen positive. Providers work in collaboration with Baby S.A.F.E. programs in case-managing pregnant women who screen positive for substance use.

The Northrop Grumman FASD implementation grant application focuses on improving prevention services for women who are using or who are at-risk of using alcohol during pregnancy. If funded, staff will be hired to build service capacity in rural communities working through the Baby SAFE and Na Lei Lokahi (Salvation Army) substance use programs in collaboration with community health centers. Staff from Baby SAFE and the Salvation Army will assist health center staff to improve their capacity to identify, screen, and intervene with pregnant women and women of child-bearing age who use or who are at high-risk for using alcohol.

HMHB, in concert with Title V, continues to convene the quarterly DOH Clinical Providers and Perinatal Providers/Advocacy Network meetings. HMHB will continue to train providers in Brief Intervention for tobacco and coordinate the "Substance Use and Pregnancy" workshops to providers. Executive Director, Nancy Partika, is co-chair for the FASD Task Force.

Perinatal advocates continue to support the appeal before the state Supreme Court of a drug addicted mother charged with manslaughter of her infant who died 2-days after birth from fatal levels of methamphetamine. The National Advocates for Pregnant Women filed an amicus curiae brief with the Court in July. The case will be heard in October 2005.

Quarterly S.A.F.E. Council meetings provide a forum for discussion of perinatal and advocacy issues surrounding pregnant women who use substances and their families. The teleconferenced meetings support information-sharing and interagency partnerships to improve statewide system functioning. Linda Rich of the Salvation Army Family Treatment Service is the chair, while Title V provides staffing for the group. The Council continues to monitor the progress of the court appeal of a woman addicted to ice, whose two day-old infant died.

Title V needs assessment work will continue with stakeholders to refine the problem analysis for prenatal alcohol and smoking. Results from the FASD Task Force assessment of services will also be incorporated into the problem analysis.

State Performance Measure 5: *The percent of teenagers in grades 9 to 12 attending public schools who report smoking tobacco within the last 30 days.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	28	25.5	25.5	23.1	23.1
Annual Indicator	27.9	15.0	15.0	13.9	13.9
Numerator		150	150	1147	1147
Denominator		1003	1003	8275	8275
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual					

Performance Objective	20.8	20.8	18.4	18.4	18.4

Notes - 2002

The data comes from the Hawaii Youth Risk behavior Survey (YRBS). Data reported prior to 2001 are weighted to the general population by the Centers for Disease Control and Prevention (CDC). The 2001 survey sample did not meet the CDC requirements for population-based weighting of the data. Thus, 2001 results are unweighted and apply only to students participating in the survey and not the general population of public high school students in the state. The 2001 data is not comparable to the weighted data from previous years. The numerator and denominator reflect the actual sample results. Objectives have been set to achieve the Healthy People 2010 target. The survey is conducted every two years, thus there is no new data for 2002.

Notes - 2003

The data comes from the Hawaii Youth Risk behavior Survey (YRBS). The 1999 survey data is weighted to the general population by the Centers for Disease Control and Prevention (CDC). The 2001 and 2003 survey sample did not meet the CDC requirements for population-based weighting of the data. Thus, 2001 and 2003 results are unweighted and apply only to students participating in the survey and not the general population of public high school students in the state. The 2001 and 2003 data is not comparable to the 1999 weighted data. The numerator and denominator reflect the actual sample results. The survey is conducted every two years.

An annual pace has been blueprinted to meet the Healthy People 2010 objective for this measure.

Notes - 2004

The data comes from the Hawaii Youth Risk behavior Survey (YRBS). Data reported prior to 2001 are weighted to the general population by the Centers for Disease Control and Prevention (CDC). The 2001 and 2003 survey samples did not meet the CDC requirements for population-based weighting of the data. Thus, results are unweighted and apply only to students participating in the survey and not the general population of public high school students in the state. The 2001-03 data is not comparable to the weighted data from previous years. The numerator and denominator reflect the actual sample results. Objectives have been set to achieve the Healthy People 2010 target. This measure will be dropped next year per findings of the 2005 Title V needs assessment.

a. Last Year's Accomplishments

The YRBS is conducted every two years, thus there is no new data for 2004. This measure reflects the State priority to reduce substance abuse. The 2004 objective was met and exceeds the Healthy People 2010 objective of 16%. However, the 2001 and 2003 Youth Risk Behavior Survey (YRBS) results are unweighted. Data from the 2 other school health surveys also corroborate the continuing decline of youth smoking.

The Tobacco Prevention and Education Program (TPEP) is the lead agency within DOH funded by the Centers for Disease Control and Prevention (CDC) through the National Tobacco Control Program. Youth prevention programs include counter-marketing, school-based prevention, community mobilization, policy and regulation.

TPEP funds the REAL program, which empowers youth to develop strategies to reduce tobacco use. TPEP funds the Youth Tobacco Survey, sponsors training on media literacy, oversees media campaigns, and supports Tobacco-Free Coalitions statewide.

To combat positive images of smoking in movies, REAL sponsored a student movie review contest that had students critique the portrayal of smoking in movies. The project helps increase awareness of the effect of tobacco use in media. Other sponsors included TPEP,

theater companies, the Coalition for a Tobacco Free Hawaii, and the Department of Education (DOE). Students shared the information in their classes and wrote articles in school newspapers.

The $1.2 million "Clear the Smoke" media campaign ran last year, financed with Tobacco Settlement funds. The program sought to warn youth about the dangers of smoking and educate the public about the harm of secondhand smoke.

The DOH Alcohol and Drug Abuse Division (ADAD) continues its ongoing efforts with the University Cancer Research Center (CRC) and county police departments to stop illegal sale of tobacco to minors. Since this annual survey began in 1996, the rates of noncompliance have dropped from 44.5% to 5.2% in 2004, one of the lowest rates in the nation. ADAD also oversees the Student Drug Use Survey.

The DOH Healthy Hawaii Initiative and Coordinated School Health programs include smoking prevention as one of three health promotion goals. The programs provide funding for staffing, teacher training, resource and curriculum support, and infrastructure development.

The DOE Peer Education Program (PEP) offers smoking cessation education in collaboration with the American Lung Association to students through 15 full time and 4 volunteer schools. PEP is a peer mentoring program in which teens are trained in 4-6 health related subjects and do presentations through various venues, such as school assemblies, fairs and the middle and elementary schools. They are also available for fellow students who need to talk.

The Hawaii law that prohibits the use of tobacco by employees in public schools went into effect in May. The law expands smoking restrictions to all adults including parents, supporters, employees, or others attending school functions.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide tobacco and substance abuse prevention education to students and community.		X	X	
2. Provide support for community coalitions to conduct prevention awareness activities.				X
3. Plan and implement strategies to prevent youth substance use.				X
4. Provide training for public school teachers to address youth substance use.				X
5. Monitor and enforce laws prohibiting tobacco sales to minors				X
6. Develop and conduct media campaigns to prevent smoking.			X	X
7. Advocate for policy to create more smoke-free environments, provide disincentives to purchase tobacco products, and continue prevention funding levels.				X
8. Improve inter-agency collaboration to build infrastructure needed to support and sustain the Coordinated School Health Program.				X
9. Develop infrastructure for prevention resource coordination.				X
10. Improve surveillance systems through inter-agency planning efforts to administer 4 school health surveys that collect student health data used for needs assessment and program planning.				X

b. Current Activities

DOH's HHI continues to support DOE Health and Physical Education staff, resources and trainings such as the State Health Education Conference to provide teachers and health educators with current health information and teaching ideas.

PEP students continue presenting tobacco prevention education to middle and elementary school students.

TPEP continues work to build community-level infrastructure by supporting Neighbor Island Tobacco-Free community coalitions and the statewide coalition. The coalitions conduct activities such as youth summits that teach teens how to tailor tobacco messages for peers and communities. TPEP continues to support the production of some of the most innovative media ads on TV, radio and in print. The Tobacco Quit Line, funded by the Tobacco Settlement and operated by Free and Clear, will be launched in July.

TPEP's school-based and school age initiatives support objectives to reduce initiation, promote awareness of health risks, and increase awareness of the tobacco industry's tactics that target and manipulate the youth market.

The Coalition for a Tobacco Free Hawai'i, which comprises about 1,000 advocates and 140 statewide agencies and businesses, hosted the second annual Kick Butts Day to honor youth activism for tobacco prevention. Students urged their legislators to continue funding prevention initiatives and support tougher smoking laws.

The state Legislature passed a bill that requires retailers who sell tobacco products to obtain a permit from the state Department of Taxation. The permit will allow for better monitoring of laws banning sales to minors, ensures retailers are selling tobacco products legally, and allows for improved collection of tobacco excise taxes. Bills that failed include those to raise the tobacco sales tax and prohibit smoking at public parks/playgrounds and beaches.

ADAD administers the State Incentive Grant (SIG) program (funded at $8.4 million over a 4 years) to support substance use prevention programs. Eighteen community based projects were developed statewide. The first 13 projects enrolled 2,374 youth and 765 adults in prevention programs. Five additional partnerships in rural communities completed intensive community assessment and planning activities through the "Communities That Care" planning process to identify their local needs and resources and select evidence-based prevention programs for implementation.

c. Plan for the Coming Year

Hawaii tobacco prevention efforts have been successful in reducing smoking among youth. The school health surveys: YRBS; Youth Tobacco Survey; and the Student Alcohol, Tobacco and Other Drug Use Survey point to decreases in smoking since 1996. Tobacco sales to minors have also dropped substantially since 1996 to the fourth lowest rates in the nation.

The drop in cigarette use is likely the result of efforts to educate teens about the health risks of smoking, the high cost of cigarettes (driven up by tobacco excise taxes), and stricter enforcement of laws banning tobacco sales to minors. State and county laws have effectively banned smoking from many public spaces, government buildings, restaurants, and schools.

Strong community advocates and the DOH TPEP program have been aggressive in their leadership to build an effective, comprehensive, statewide tobacco-control program. Their efforts have generally changed the social norms in Hawaii about smoking over the past 15 years.

Hawaii's tobacco prevention efforts have clearly benefited from Tobacco Settlement funding. Unlike many other states, Hawaii uses much of the Tobacco Settlement funds, roughly $40 million a year, for health related programs. Hawaii ranks seventh in the U.S., for funding programs to prevent smoking, spending $8.9 million last year.

For these reasons, adolescent smoking as a state performance measure will be dropped in the next 5 year reporting period.

Continued success in tobacco prevention depends on whether the state continues to properly fund and implement its tobacco prevention programs. Thus, advocacy efforts will continue to focus on protecting Tobacco Settlement funds from being diverted to other program areas in the state budget. Tobacco prevention advocates will continue to pursue legislation to create more smoke-free environments including airports, hospitals, and public parks and beaches. Legislation to increase state excise taxes on tobacco sales will also likely be pursued.

TPEP will continue its statewide activities in partnership with community groups like the Coalition for a Tobacco Free Hawaii, Campaign for Tobacco-Free Kids, American Heart Association, American Cancer Society and American Lung Association.

The REAL program is funded until the end of 2005. The Hawaii Community Foundation will be developing a request for proposal for a youth empowerment program for tobacco cessation to continue the effort.

The DOE PEP plans to expand the program to 7 more schools in the 2006-07 school year.

The Adolescent Survey Committee (ACS) is responsible for the planning, distribution and collection of the 2 health surveys (YRBS and the HYTS) to the middle and high schools. To assure an adequate sample is collected for each health survey, a statewide random sampling of approximately 2,200 students will be collected per survey during school year 2005-2006. The sample size is more manageable than those collected in 2003 which were designed to provide more detailed school level data.

State Performance Measure 7: *The rate of confirmed child abuse/neglect reports per 1000 for children aged 0-5 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	12	12	11	11	13.3
Annual Indicator	15.7	17.0	15.8	16.1	15.0
Numerator	1487	1636	1560	1615	1562
Denominator	94446	96281	98543	100238	103799
Is the Data Provisional or Final?				Final	Provisional

	2005	2006	2007	2008	2009
Annual Performance Objective	12.9	12.5	12.1	11.8	11.4

Notes - 2002

The data for 2001 was revised. Data reported for this measure is not comparable from year to year due to several changes made by the Department of Human Services (DHS) in their data collection methods and definitions over the years. When DHS resolves current data collection issues, the objectives will be adjusted.

The annual population estimates produced by the U.S. Census Bureau are usually used in reporting population based data for the State of Hawaii. However, due to the unexpected delays in the releasing of the age-sex population estimates for the years 2001 and 2002, the DOH/FHSD population estimation was utilized.

The measure will be updated with the population estimate data if and when it becomes available.

Notes - 2003

The data for 2001 was revised. Data reported for this measure is not comparable from year to year due to several changes made by the Department of Human Services (DHS) in their data collection methods and definitions over the years. When DHS resolves current data collection issues, the objectives will be adjusted.

The indicator data for 2001 and 2002 was updated with the U.S. Census Bureau’s age-sex population estimates which were not yet released at the time of last year’s application report.

The annual population estimates produced by the U.S. Census Bureau are usually used in reporting population based data for the State of Hawaii. However, due to the unexpected delays in the releasing of the state age-sex population estimates for the year 2003, the DOH/FHSD population estimation was utilized.

Notes - 2004

Data reported for this measure is not comparable from year to year due to several changes made by the Department of Human Services (DHS) in their data collection methods and definitions over the years. Records from 1999 and before are designated by the case report date, records from 2000 and after are designated by case disposition date. All data is reported by federal fiscal year.

The indicator data for 2001-2004 were updated with the U.S. Census Bureau’s age-sex population estimates released on March 10, 2005. This measure will be dropped next year per findings of the 2005 Title V needs assessment.

a. Last Year's Accomplishments

The measure reflects the priority to reduce family violence and child abuse and assure parenting support and information is made available to all families. The FY 2004 indicator is 15.9. The objective was not met.

According to Child Welfare Services (CWS), the number of reports is increasing, largely due to the growing methamphetamine use and prenatally exposed newborns. The number of children entering foster care is also increasing. Although real numbers of cases are increasing, the rates have remained relatively stable with little improvement.

CWS data reflects a portion of all abuse cases-those that occur in the home. Other sources of data include the Children's Justice Centers, which provide a safe setting for the police and

providers to conduct forensic interviews and counseling services to victims of non-family sex abuse. The Centers receive 1200-1400 reports per year, about one-third of them concern children ages 0-5. However, most of the Centers' clients were abused years before.

Much of Title V's efforts are assurance activities through contracting monitoring of services. DOH continued its ongoing contracts with nonprofits for the provision of family strengthening and family support services for the prevention of child abuse and neglect. Title V administers two population-based programs: Hawai'i Healthy Start universal screening to identify families at risk for child abuse and neglect and a parenting advice phone line. Of those families receiving Healthy Start services, 99% had no confirmed reports of child abuse or neglect.

Title V also co-sponsored the annual state child abuse and neglect conference.

Title V's targeted programs including home visiting of families identified as at-risk, parent support groups, outreach to pregnant and new mothers who use substances, parent/child play groups, respite, and counseling services for children who witness violence. These ongoing programs have served as the core of DOH's family strengthening services for many years. Title V administers the Hawaii Children's Trust Fund, which contracts for targeted service provision to support families and prevent child abuse and neglect.

The Coordinated School Health program, which is a cooperative agreement with DOH and DOE, funds resource personnel to implement health content and performance standards that includes violence prevention education. The standards assure children in the public schools will receive violence prevention information as part of the health curriculum.

The Hawaii Child Death Review continued its work to reduce preventable deaths to children, including cases of child abuse and neglect, by partnering with organizations to educate the public about causal factors and advocate for policy or administrative changes.

Efforts to reduce child abuse and neglect at the systems level are varied throughout the state, implemented by various coalitions, councils and boards. Title V staff participate on these groups.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conducts screening of all civilian hospital births for risk factors of child abuse and neglect.			X	
2. Provides home-visiting services to families at risk for child abuse & neglect.		X		
3. Contracts to provide family support and development services.		X		X
4. Contracts to provide outreach and pretreatment services to substance abusing pregnant women.		X		X
5. Administers Children's Trust Fund to provide grants for family support programs.				X
6. Contracts to provide statewide hotline for parents who have questions about parenting.			X	X
7. Assures violence prevention is integrated into all Title V service programs.				X
8. Participates on community coalitions and councils dedicated to child				

and family well being.				X
9. Implementation of Child Welfare Services Federally mandated performance improvement plan.				X
10. Increase service coordination between Hawaii Healthy Start child abuse prevention program and Child Welfare Services to improve program outcomes through inter-agency task force.				X

b. Current Activities

The Title V MCH Branch established a Violence Work Group that continues to integrate violence prevention strategies within the Branch programs. The Branch also initiated an interagency task force entitled the Child Safety Collaborative, whose goal is to assure that the state has child safety systems that are coordinated, effective and well funded. This group is staffed by Title V staff.

Title V continued to operate its two population-based services, Healthy Start (HS) a child abuse prevention program and the Parent Line. To date, HS has served 73% of eligible families (14% of all civilian births); 99% of these families have had no confirmed reports of child abuse or neglect. For more information on Healthy Start see narrative for SP 14.

Contracts for Family Support programs also continued. Using the Hawaii Children's Trust fund, Title V co-sponsored the annual state child abuse conference and provide funding for family strengthening programs.

Title V continue efforts to network, coordinate and plan, and develop policy through active participation on numerous coalitions and councils that advocate for the well being of children and families. These partnerships function at the state policy level and at the community level including: Legislature's Keiki Caucus community input group, Legislature's Child Protection Roundtable, School Readiness Task Force, Injury Prevention Advisory Committee, The Awareness Foundation/United Approach to Violence Steering Committee, Title IVB-2 Statewide Council, Military Family Advocacy Coordinating Council, and Good Beginnings Alliance, Keiki (Child) Injury Prevention Coalition, Never Shake a Keiki (Child) Task Force, and Coalition for Dads.

The Child Death Review program is finalizing data from years 1997-2000 for release of a 2nd CDR report. Members of the CDR Council and local teams received training in June 2005 from the National MCH Center for Child Death Review on the National Child Death Review Case Reporting System. The Child Death Review Program revised its policies and procedures manual, and facilitated scene-investigation training for two neighbor islands and a community college Emergency Services program.

The federal Child and Family Services Review (CFSR) of Hawaii was completed in 2003. The DHS was found to be in conformity with only 1 of 6 outcome factors and 2 out of 7 systemic factors. The Department of Human Services (DHS), which houses the CWS, is now implementing its Performance Improvement Plan.

The 2005 Legislature extended the work of an interagency task force charged with developing a plan to coordinate services provided by Hawaii Healthy Start and the CWS. The task force is developing agreements between the programs to permit HHS to provide case management services to CWS children and is implementing a general plan for data sharing. The task force will submit a report of findings and recommendations to the 2005 Legislature.

c. Plan for the Coming Year

While family violence issues remain an important concern for the community, prevention of

child abuse did not emerge as a high priority given the extensive institution support and funding dedicated to this public health issue. Although rates have not shown any major improvement over the last 5 years, there are many initiatives underway to improve the effectiveness of existing programs and strengthen coordination some of which are described in the narrative. Moreover, child abuse is a well-established public concern that continues to receive regular attention from the media and policymakers compared to other emerging health issues. Thus, this measure will be dropped next year.

The interagency Task Force charged to coordinate services provided by Hawaii Healthy Start (HS) and the Child Welfare Services (CWS) has made considerable progress over the 2 years it has met. In FY 2005-06 DHS has earmarked $3.2 million of Temporary Assistance to Needy Families (TANF) funding to expand a 2004 pilot project of "Enhanced Healthy Start" services that enables CWS cases to be referred to and be served by HS providers.

Over the next year the Task Force will continue to explore the feasibility of implementing improvements in 4 areas: 1) evaluation of programs and tools, 2) recruitment and retention of families in HS, 3) comprehensive health assessment of young foster children, and 4) improved access to treatment services.

The implementation of the Federally mandated Performance Improvement Plan (PIP) for CWS will continue concurrent to the work of the Task Force. The implementation of the PIP is important to the work of the Task Force since it is anticipated that there will be significant changes to the ways in which child welfare services are coordinated and delivered. The impact of these changes are yet to be known.

State Performance Measure 8: *The percent of teenagers in grades 9 to 12 attending public schools who report being involved in a physical fight (within the last 12 months) .*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	30.6	28.8	28.8	27.1	27.1
Annual Indicator	30.6	25.9	25.9	26.0	26.0
Numerator		274	274	2222	2222
Denominator		1057	1057	8541	8541
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	25.5	25.5	24	24	22.5

Notes - 2002

The data comes from the Hawaii Youth Risk behavior Survey (YRBS). Data reported prior to 2001 are weighted to the general population by the Centers for Disease Control and Prevention

(CDC). The 2001 survey sample did not meet the CDC requirements for population-based weighting of the data. Thus, 2001 results are unweighted and apply only to students participating in the survey and not the general population of public high school students in the state. The 2001 data is not comparable to the weighted data from previous years. The numerator and denominator reflect the actual sample results. The objectives are set to reflect a decrease of 3% based on the FY 2000 indicator. The survey is conducted every two years, thus there is no new data for 2002.

Notes - 2003

The data comes from the Hawai'i Youth Risk behavior Survey (YRBS). The 1999 survey data is weighted to the general population by the Centers for Disease Control and Prevention (CDC). The 2001 and 2003 survey sample did not meet the CDC requirements for population-based weighting of the data. Thus, 2001 and 2003 results are unweighted and apply only to students participating in the survey and not the general population of public high school students in the state. The 2001 and 2003 data is not comparable to the 1999 weighted data. The numerator and denominator reflect the actual sample results. The survey is conducted every two years.

Notes - 2004

The data comes from the Hawaii Youth Risk behavior Survey (YRBS). Data reported prior to 2001 are weighted to the general population by the Centers for Disease Control and Prevention (CDC). The 2001 and 2003 survey samples did not meet the CDC requirements for population-based weighting of the data. Thus, results are unweighted and apply only to students participating in the survey and not the general population of public high school students in the state. The 2001-03 data is not comparable to the weighted data from previous years. The numerator and denominator reflect the actual sample results. Objectives have been set to achieve the Healthy People 2010 target. This measure will be dropped next year per findings of the 2005 Title V needs assessment.

a. Last Year's Accomplishments

This measure reflects the State priority to reduce family violence. Data for this measure comes from the Youth Behavioral Risk Surveillance (YRBS), which is conducted bi-annually, thus there is no new data for 2004. The 2003/2004 objective was met and exceeds the HP 2010 objective of 33.3%.

Determining progress for this measure is problematic, however, because the 2003 YRBS data, like the 2001 YRBS data is unweighted and represents only the students surveyed and is not representative of all Hawaii public high school students. The 2003 sample is substantially larger (n=8,541) than 2001 (8,541 vs. 1,057), falling just short of the Centers for Disease Control threshold for weighting. Alternative methods are being explored to weight the 2003 data.

The Department of Education (DOE), under Chapter 19 of its administrative rules, continues to report data on students suspensions indicates a troubling increase in violent offenses that include insurbordination, disorderly conduct, harassment, and assault. Increases may have resulted in part from greater emphasis on dealing proactively with violence. And none of the public schools in Hawaii has been identified as a "persistently dangerous school" as defined in the federal "No Child Left Behind Act."

In response to increased concern over school violence some 150 public schools have used the anti-bullying program entitled "Breaking Out of the World Game" on their campus. Reporting substantial decreases in student behavioral problems and suspensions, the program has been expanding to more schools. Students attend an intense 3-day workshop developed by an international non-profit, the Word Youth Network.

Title V population based programs focus on violence prevention education and outreach. Title V contracts with the Sex Abuse Treatment Center (SATC) at the Kapiolani Medical Center and DOE Peer Education Program (PEP) to provide sex assault prevention education to youth

statewide. PEP educators provided 427 middle and high school sex assault presentations to 13,624 students. PEP educators also provided sex assault information to 8,938 parents through various methods including flyers.

SATC provided training to agency staff serving populations with disabilities, immigrants and runaway youth. The Hawaii Coalition Against Sexual Assault (HCASA) partners with the sexual assault providers to increase public awareness about sexual assault through activities during Sexual Assault Awareness Month. The State Domestic Violence Prevention Special Funds (DVPSF) supported contracts for violence prevention including sex assault prevention for teens and general violence prevention education.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide violence prevention education including sexual assault to students and community.			X	
2. Contract to provide sex assault prevention education and trainings through the Sex Assault Treatment Center.			X	X
3. Improve inter-agency collaboration to build the infrastructure needed to support and sustain the Coordinated School Health Program.				X
4. Provide teacher training on healthy youth develop and violence prevention.				X
5. Improve surveillance systems through inter-agency planning efforts to administer 4 school health surveys that collect student health data used for needs assessment and program planning.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The DOH released a violence prevention report that indicated Hawaii had lower than national rates for interpersonal violence including youth violence, homicide, violent crime and rape. See PM 15 for additional information.

The Adolescent Survey Committee (ASC) continues work to improve school health survey data collection. DOE's Comprehensive Student Support System (CSSS) is being developed to assure all students have a multi-faceted system of positive behavior supports.

The DOH Healthy Hawaii Initiative continued to fund University Summer Institute teacher training to promote resiliency in youth and safe environments. For summer 2005, training is on school violence prevention.

Hawaii Building Partnerships for Youth (BPY) program's PowerPoint presentation on after-school hour programming is listed on the BPY web site to continue to support healthy youth development projects.

DHS will be using surplus Temporary Assistance for Needy Families (TANF) funds to provide

more non-school hour programs for youth throughout the state. These Uplink programs are designed to prevent teen pregnancy using a healthy youth development approach and are also an essential prevention component of the State Drug Control Plan.

The DOE PEP continued sexual assault prevention education to youth at 19 public schools and SATC continued to provide sex assault training to health agencies. SATC is developing three graded sexual assault prevention curricula for use in Hawai‘i schools. Individual public schools continue to employ anti-bullying education programs to reduce incidents of behavioral problems and suspensions.

The DVPSF continued to support teen dating violence prevention activities and to sponsor "Girl Fest", a series of violence prevention activities and resources targeted to young girls/teens. Activities included a gender violence workshop conducted by national violence prevention advocate, Jackson Katz. In September, Girl Fest will present 4 national male leaders in gender violence prevention at public schools, post-secondary schools and community events.

DV funds also supported 1) Prevent Violence Hawaii, a broad coalition of service providers that are developing a unified approach to violence prevention; 2) counseling services to young children exposed to domestic violence in the home; and 3) an assessment/training at six community health centers on Oahu to integrate family violence screening protocols into clinical practice.

MCHB Violence Prevention Workgroup continued to meet to coordinate and integrate violence prevention efforts in the Branch as related to provider data, tools and resources, policies and procedures, training and evaluation.

HCASA is developing a PSA on date rape for use in 2005-2006.

As part of the Title V Needs Assessment, youth violence/bullying was examined as a possible priority area and a review of literature and prevalence data was completed. However, it was not picked as a priority by stakeholders.

c. Plan for the Coming Year

Reporting of this state performance objective will be discontinued.

SATC will continue to train agency and professional staff on sexual assault prevention and intervention. SATC will continue to provide educational resources to the community. The DOE PEP program will continue violence prevention education in Hawai‘i public schools. DV Special Funds will continue to support youth violence prevention activities. HCASA will continue to carry out public awareness activities.

The UH College of Education with support from DOH and DOE, will continue its teacher trainings and movement toward standards-based health curricula. The goal is to integrate the priority health areas as addressed in the Hawaii Health Education Standards, violence prevention being one area, as part of "building safe and positive learning community."

The state Department of Education will be working to implement legislation passed in 2005, House Resolution 23, which addresses the concern of bullying and intimidation in schools. It urges schools to initiate policies on student conduct and to promote a school environment that encourages learning.

State Performance Measure 11: *The percent of pregnancies (live births, fetal deaths,*

abortions) that are unintended.

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	49.8	47.8	45.9	43.9	41.9
Annual Indicator	53.5	55.7	53.4	49.6	49.6
Numerator	11646	11896	11574	10894	10894
Denominator	21772	21365	21685	21975	21975
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	49	48	47	46	45

Notes - 2002

Data for this measure comes from the Hawaii Pregnancy Risk Assessment Monitoring System (PRAMS) and vital statistics. DOH started PRAMS in June 1999 as a pilot project. The year 2000 is the first full year of PRAMS data. The 2000 data is the most recent set of available data. Objectives have been set to achieve the Healthy People 2010 target.

Notes - 2003

This is a new State Performance Measure added in for the five-year report period, FY 2001-2005.

Data for this measure comes from the Hawai‘i Pregnancy Risk Assessment Monitoring System (PRAMS) and vital statistics. DOH started PRAMS in June 1999 as a pilot project. The year 2000 is the first full year of PRAMS data. Data for the year 2002 is the latest available.

Data is for resident population and is by calendar year. Data for the year 2000 was revised with an updated birth, fetal death, and ITOP data files.

An annual pace has been blueprinted to meet the Healthy People 2010 objective for this measure.

Notes - 2004

Data for the year 2003 is the latest available. FY 2004 data will be updated next year. Data is for resident population and is by calendar year. Based on 3 years of data, objectives for this measure have been revised to reflect more achievable goals with a 1% reduction each year.

Data for this measure comes from the Hawai‘i Pregnancy Risk Assessment Monitoring System (PRAMS) and vital statistics. DOH started PRAMS in June 1999 as a pilot project. The year 2000 is the first full year of PRAMS data.

This State Performance Measure was added in for the five-year report period, FY 2001-2005 and will continue as a state performance measure and priority through 2010.

a. Last Year's Accomplishments

This measure reflects the state MCH priority to reduce the rate of unintended pregnancies in Hawaii. The FY 2004 indicator is 49.6% using the FY 2003 indicator, the latest available data from the Pregnancy Risk Assessment Monitoring System (PRAMS) as well as vital statistics data on abortions and fetal deaths. The objective was not met, but rate is declining. Hawaii rates are comparable to other states in the U.S. which range from 60% to 49%.

In an effort to reduce unintended pregnancy in Hawaii, DOH's Family Planning Program (FPP) provided family planning (FP) community health education and outreach services on six islands as well as clinical FP services for uninsured women and men at 47 clinic locations statewide.

Direct services included comprehensive FP clinical examinations; enabling services included FP health education, translation services, case management and referrals. Title X FP funds provided 24,635 subsidized clinical FP visits to 15,733 uninsured individuals through contracts with community clinics statewide.

Population based programs focused on raising awareness of available FP services, particularly emergency contraception (EC), through public service announcements, presentations, health fairs, and distribution of education/promotional materials. All community clinics offering FP services were encouraged to be listed on national EC Hotlines and websites and during 2004 EC was provided on 1,746 occasions to FP clients.

Community-based prevention occurs through Community Health Educators presentations and media initiatives targeting high-risk populations including adolescents, males, homeless, disabled and substance abusers. As part of its ongoing effort to reach local residents with limited English proficiency (LEP), FPP's health education team organized and produced an FP educational program for KNDI radio. This program was broadcast in nine locally relevant languages: Tongan, Filipino, Samoan, Spanish, Chinese, Okinawan, Vietnamese, Laotian, and Marshallese.

Teen pregnancy prevention activities are increasing with support from surplus TANF funds. See PM 8 narrative for activities targeting adolescents.

In response to both changing federal Title X guidelines and shifting program and provider needs, FPP revised their client tracking software. Title V staff installed the new software and trained personnel at 21 clinic sites statewide. Title V staff also provided ongoing training to clinic data entry staff, reviewed common data errors, and modified the data collection system as necessary. The change has led to improvements in data quality, timeliness of reporting, and increased collaboration with providers.

Legislation was passed in 2003 that allowed Hawaii pharmacists to dispense EC. Since then, the EC Interagency Work Group has worked to implement the legislation. In 2004, 250 local pharmacists attended a training sponsored by the Hawaii Pharmacists Association. In May, local pharmacies began to dispense EC to the public.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Contract to provide family planning services to uninsured women statewide.	X	X		X
2. Contract to provide reproductive health education targeting at-risk		X		X

populations.				
3. Promote access to and awareness of emergency contraception through subsidized supplies, education and advocacy.			X	X
4. Provide ongoing technical assistance and training for providers with revised data collection system used to monitor contracts.				X
5. Conduct the Pregnancy Risk Assessment Survey (PRAMS) to collect data on unintended pregnancy.				X
6. Analyze and disseminate PRAMS data for programming and policy.				X
7. Analyze and disseminate Family Planning Annual Report (FPAR) data for policy.				X
8. Collect FPAR data and submits yearly report to federal Office of Population Affairs (OPA).				X
9. Conduct site-based visits to all facilities receiving Title X funds for technical assistance, support, and monitoring.				X
10. Continue needs assessment work to refine problem analysis and analyze the service system with stakeholder input.				X

b. Current Activities

In an effort to reduce unintended pregnancy in Hawaii, the FPP offers preventive FP services described in the previous FY 2004 report. The FPP continues to assure access to clinical services by contracting with community clinics on six islands to provide subsidized family planning services to uninsured women and men at 47 clinic locations statewide.

The FPP collaborates with partners to provide population-based community health education and outreach services. Although limited to half-time positions, the health education contracts continue with eleven FP Health Educators statewide.

The Department of Health's FPP EC promotion campaign continues to provide educational presentations, outreach activities, plays, and health clinics. The EC Interagency Work Group meets to collaborate on EC access and track the progress of pharmacy-dispensed EC. Currently there are 145 pharmacists in 36 pharmacies in Hawaii registered to dispense EC. Public awareness and education occurs in part through radio ads sponsored by Healthy Mothers Healthy Babies.

The M.A.N. Project, through Waikiki Health Center's Youth Outreach Program, involves males in FP through health education and clinical services. Targeted towards homeless males aged 13-19, the project works to improve participants' understanding of family planning methods, improve and increase partner communication skills, increase their ability to obtain contraception, and increase consistent condom use. See PM 8 narrative for other activities targeted at adolescents.

As part of the Title V 5-year needs assessment, unintended pregnancy was identified as a continuing health priority. Stakeholder input was solicited through existing community groups and a survey conducted at a Perinatal Summit held in 2004. A problem analysis was begun to identify major risk/protective factors and existing services. Stakeholder input was solicited for the problem analysis at a statewide meeting held in October 2004.

c. Plan for the Coming Year

The indicator data comes from PRAMS and vital statistics data on abortions and fetal deaths. Weighted data for the 2004 PRAMS will be available for next year's report. Based on 3 years of data, objectives for this measure have been revised to reflect more achievable goals with a 1%

reduction each year.

Title V is re-evaluating the broad definition of "unintendedness" and whether the current results from PRAMS are useful in identifying the women most in need of limited FP resources. The PRAMS Project Coordinator and MCH Epidemiologist are analyzing the unintended responses from the PRAMS survey to identify those pregnancies that are "wanted," "unwanted," "ambivalent," and "mistimed." Results have been presented in a Title V Work Group and are being developed for eventual publication. The PRAMS staff will continue to analyze results capturing the complexity of circumstances under which women unintentionally get pregnant. The data will be used as a basis to identify high-risk groups, gaps in services, and strategies to reduce unintended pregnancy in Hawaii.

As part of on-going Title V needs assessment, work will continue with stakeholders to refine the problem analysis. More detailed information on program effectiveness will be compiled to identify evidence based practices locally. Research will also continue to identify evidence base practices in the literature. The information will be used to analyze the service system and strategically plan with stakeholders to reduce rates of unintended pregnancy.

Media campaigns are effective tools in the prevention of unintended pregnancy by increasing community awareness of the problems associated with unintended pregnancies, the importance of family planning, and access to subsidized services. However, resources to contract media are in short supply. Title V will be working with stakeholders to identify innovative strategies for outreach and education in a time of diminishing resources.

The clinical services and health education contracts will continue as described in the previous narrative. Health educators continue to focus their efforts on teen pregnancy prevention. See narrative for NP 08 on teen births. Work to improve provider contract data continues to be a priority for MCH data staff. The data staff is also identifying areas of information overlap among MCH programs that could offer opportunities to integrate data collection across multiple programs. Integrating program data collection reduces redundancy for both MCH personnel and providers and improves the usefulness of the data.

State Performance Measure 12: *Percent of infants with hearing loss who are receiving appropriate intervention services by age 6 months.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	60	82	88	90	82
Annual Indicator	73.7	59.3	63.8	61.8	64.3
Numerator	42	35	30	34	36
Denominator	57	59	47	55	56
Is the Data Provisional or Final?				Final	Provisional

	2005	2006	2007	2008	2009
Annual Performance Objective	65	67	70	72	75

Notes - 2003

This is a new State Performance Measure added in for the five-year report period, FY 2001-2005.

Data for this measure has been updated. The numerators are revised to match the number receiving Early Intervention (EI) services by 6 months as reported on 1998 through 2002 Early Hearing Detection & Intervention (EHDI) federal reports to the Centers for Disease Control. These reports run calendar year. The denominator also is revised to match the number with permanent hearing loss as reported on 1998 through 2002 EHDI federal reports.

The 2003 data is still preliminary because not all EI information is available.

Objectives for FY 2004-2007 were revised based on the updated indicators.

Notes - 2004

The denominator for this measure is the number of infants with permanent hearing loss who did not pass the newborn screen. The numerator is the number of these infants who were referred for Early Intervention services by 6 months of age. Data is reported by calendar year. Data for FY 2002-2003 were updated. Data for FY 2004 is provisional and will be updated in next year's report. Objectives were revised based on reported data to date.

a. Last Year's Accomplishments

The FY 2004 indicator was 64.3%.

The Newborn Hearing Screening Program (NHSP) provided information to families of infants with possible hearing loss or risk factors for late onset hearing loss about accessing recommended audiological follow-up and early intervention services. As needed, diagnostic audiological evaluations and transportation were arranged. Infants with permanent hearing loss were referred for early intervention services. Publications included "Information for Early Intervention Specialists", "The Good Hearing" brochure, "Hawaii State Resource Guide for Families of Children with Hearing Loss" and "Let's Listen" booklet for parents.

NHSP is a program in the Early Intervention Section (EIS)/CSHNB, which provides early intervention services for infants/toddlers 0-3 years who are developmentally delayed or biologically/environmentally at risk, as mandated by Part C of Individuals with Disabilities Education Act (IDEA).

Working relationships with pediatric audiologists were maintained to facilitate timely and appropriate evaluations for infants who failed screening. CSHNB collaborated with the University of Hawaii/School of Medicine/Department of Pediatrics in arranging March 2004 educational sessions on mild hearing loss by Dr. Noel Matkin for pediatricians, speech pathologists, social workers, public health nurses, and other providers.

The Early Intervention (EI) Hearing Specialist (Deaf Educator) assisted early intervention programs, providers, and families in serving children with hearing loss. The Hearing Specialist made home visits to address the individualized needs of families. Working relationships continued with Gallaudet University Regional Center, Hawaii Deaf-Blind Project, Hawaii Services on Deafness, Hawaii Center for the Deaf and Blind, and Kapiʻolani Community College American Sign Language (ASL) Interpreter Program. Partnerships with two cochlear implant teams were established.

The hearing aid and FM system loaner bank was expanded for audiologists to recommend to families. The lending library of educational materials was expanded and a list was provided to families/staff.

'Ohana Time, an informational/support group for families with children with hearing loss and specialized communication, began meeting quarterly. Families from all over the state attended meetings to network with other families and learn about community resources. The Deaf Mentor/Parent Advisor pilot continued to provide individualized family support in learning about Deaf culture, understanding the needs of infants with hearing loss, and learning communication techniques to foster language development. Updated curriculum training was offered for Parent Advisors in August 2004.

Funding support was from the Hawaii Early Childhood Hearing Detection and Intervention project (MCH Bureau grant) and Part C of IDEA.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Inform families of infants w/ hearing loss about audiological evaluation and early intervention.		X		
2. Assist families in arranging needed audiological evaluations and transportation support.	X	X		
3. At family request, refer infants with permanent hearing loss for early intervention services.		X		
4. Provide consultation to early intervention staff on treatment planning for infants with hearing loss.		X		X
5. Develop lending libraries with videos and other materials on management and other aspects of hearing loss.		X		X
6. Pilot a Deaf Mentor Program on Oahu and monitor for developmental impact and family satisfaction.	X	X		X
7. Collaborate with other community deaf education services for families of infants with hearing loss.		X		X
8. Provide workshops and training to improve understanding of hearing loss and early intervention/other services.				X
9. Monitor/track audiological evaluations results, hearing, amplification, and early intervention enrollment.				X
10. Research study of service history and developmental status of children with congenital hearing loss.				X

b. Current Activities

NHSP continues to provide information to families of infants with possible hearing loss or at risk for late onset hearing loss about accessing services. Audiological evaluations and related transportation support are arranged, and infants with permanent hearing loss are referred for early intervention services. Diagnostic results of audiological evaluations authorized/paid by EIS, confirmed hearing status, amplification, and early intervention enrollment status are monitored and tracked.

The EI Hearing Specialist provides early intervention services for children under 3 years old

with hearing loss, their families, and IFSP teams. Individualized services and communication plans are developed. The EI Hearing Specialist also provides transition support into Department of Education and other programs (e.g., Head Start, community preschools). Language Enrichment Playgroups are provided as needed to enhance language development and communication skills through sign language and speech.

Inservice training continues for care coordinators, early intervention providers, Deaf Mentors and Parent Advisers to improve understanding of how hearing loss can affect development and to improve quality of early intervention services for children with permanent hearing loss. Consultation is provided to care coordinators regarding treatment planning and requesting hearing aids and other amplification devices through EIS. A lending library resource continues.

The Deaf Mentor and Parent Advisor Program continues serving six families on Oahu. The pilot program is being evaluated for developmental impact and family satisfaction. Evaluation results are used for program improvements on Oahu and as a model for expansion of the program to neighbor islands.

‘Ohana Time, informational family support meetings, are offered quarterly and provide the opportunity for families to learn more about community resources, Deaf culture, adult perspectives, literacy activities, early intervention programs and transition topics. Needs assessments are conducted with families to obtain input on the type of support requested. Input will be reviewed and utilized for planning purposes.

CSHNB received a 3-year grant from the MCH Bureau for a Baby Hearing Evaluation and Access to Resources and Services (HEARS) project to continue to improve newborn hearing screening and follow-up in Hawaii.

With funding from the Centers for Disease Control and Prevention (CDC)/EHDI cooperative agreement, CSHNB is conducting a research study of the service history and developmental status of children with congenital hearing loss in Hawaii. Participating parents complete a detailed questionnaire, and information is collected from providers and schools who know the child.

c. Plan for the Coming Year

Objectives for FY 2004-2007 were revised based on the updated indicators for FY 1999-2003. Provisional data for FY 2004 will be updated in next year's report.

NHSP will continue to provide information to families of infants with possible hearing loss or at risk for late onset hearing loss about how to access recommended audiological follow-up and early intervention services. As needed, audiological evaluations and related transportation support will be arranged, and infants with permanent hearing loss will be referred for early intervention services. Diagnostic results of audiological evaluations authorized/paid by EIS, confirmed hearing status, amplification, and early intervention enrollment status will continue to be monitored and tracked.

The EI Hearing Specialist will continue to provide direct services to families, early intervention staff and transition teams. The specialist will expand the support groups for families with children with hearing loss to neighbor island communities. Input will be obtained on an ongoing basis from families regarding the types of services they are seeking. This information will be used for planning purposes.

The Deaf Mentor and Parent Advisor pilot project will continue. In-service training and consultation to care coordinators and program staff will continue. ASL workshops and SKI*HI language assessment training will be offered to program staff. The lending libraries of

educational materials, hearing aids and FM systems will continue, and educational materials will be updated. Ohana Time meetings will continue quarterly to encourage direct parent-to-parent contact and support. A parent-led sign language playgroup is being sponsored to support the program.

Collaboration with community resources such as the Cochlear Implant centers, Hawaii Center for the Deaf and the Blind, Galluadet University Regional Center, and the Deaf-Blind Project will continue.

The CDC/EHDI research study to examine service history and developmental status of children with congenital hearing loss in Hawaii may continue. The cooperative agreement ends September 2005; however, an extension for an additional year will be requested to complete the study.

State Performance Measure 13: *The percent of teenagers in grades 9 to 12 attending public schools who are overweight.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	10	9	9	8	8
Annual Indicator	9.0	12.1	12.1	13.2	13.2
Numerator		119	119	1065	1065
Denominator		986	986	8068	8065
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	13	13	12	12	11

Notes - 2002

The data comes from the Hawaii Youth Risk behavior Survey (YRBS). Data reported in 2000 is weighted to the general population by the Centers for Disease Control and Prevention (CDC). The 2001 survey sample did not meet the CDC requirements for population-based weighting of the data. Thus, 2001 results are unweighted and apply only to students participating in the survey and not the general population of public high school students in the state. The 2001 data is not comparable to the 2000 weighted data. The numerator and denominator reflect the actual sample results. The objectives are set to achieve the Healthy People 2010 target. The survey is conducted every two years, thus there is no new data for 2002.

Notes - 2003

This is a new State Performance Measure added in for the five-year report period, FY 2001-2005.

The data comes from the Hawaii Youth Risk behavior Survey (YRBS). The 1999 survey data is weighted to the general population by the Centers for Disease Control and Prevention (CDC). The 2001 and 2003 survey sample did not meet the CDC requirements for population-based weighting of the data. Thus, 2001 and 2003 results are unweighted and apply only to students participating in the survey and not the general population of public high school students in the state. The 2001-03 data is not comparable to the weighted data from previous years. The numerator and denominator reflect the actual sample results.

Notes - 2004

The data comes from the Hawaii Youth Risk behavior Survey (YRBS). Data reported prior to 2001 are weighted to the general population by the Centers for Disease Control and Prevention (CDC). The 2001 and 2003 survey samples did not meet the CDC requirements for population-based weighting of the data. Thus, results are unweighted and apply only to students participating in the survey and not the general population of public high school students in the state. The 2001-03 data is not comparable to the weighted data from previous years. The numerator and denominator reflect the actual sample results. Objectives have revised based on YRBS data.

a. Last Year's Accomplishments

Data for this measure comes from the 2003 Youth Behavioral Risk Surveillance (YRBS), that indicates 13.2% of the public high school students surveyed are overweight (see caveat in data notes). The survey is conducted every two years, thus there is no new data for 2004. The 2004 objective was not met.

Other data sources to assess childhood overweight continue to be sought by the Department of Health (DOH). The Community Health Division (CHD) is compiling data from health forms submitted at the time of kindergarten entry. According to the data from the Pediatric Nutrition Surveillance System provided by WIC, Hawaii rates for overweight children under 5 years of age are comparable to national rates.

There is substantial activity in the State to promote better nutrition and physical activity for school age children through the DOH Healthy Hawaii Initiative (HHI) using funding from the Tobacco Settlement. Through HHI, DOH partnered with the Department of Education (DOE) to develop a Coordinated School Health program (CSHP) to improve nutrition, increase physical activity, and reduce tobacco use among public school students.

Resource teachers were hired to implement the DOE Health Education Standards adopted in 1999 to develop and promote skills-based health education to help students practice healthy behavior.

HHI in partnership with other agency support have been successful in building the school health education infrastructure needed to provide on-going professional development and training for Hawaii's 13,000 teachers in health and physical education. CSHP professional development activities for teachers include conferences, workshops, technical assistance, and credited university summer courses.

HHI also funded numerous community based health promotion activities. Projects included development of biking/walking paths and establishment of Youth Councils on Healthy Living. HHI also supports Nutrition and Physical Activity Coalitions (NPAC) on the neighbor islands.

HHI continued its public education campaign, "Start Living Healthy," to promote small, achievable changes to improve health. The campaign employs ads, community activities, a website, giveaways, and development of community partnerships. In June a new campaign was launched, "1% or Less Is Best," to help raise the public's awareness of the value of switching to low fat milk. As part of the campaign, public schools switched from serving 2% to 1% milk.

Because of Hawaii's multi-ethnic population, local food choices differ considerably from the nation. To address this, the 5-A-Day Coalition published two new brochures with a Hawaii focus-Eating 5 a Day in Hawaii and Eating by Color.

Programs continue to work collaboratively to provide services to increase physical activity and nutrition in children. WIC continues to provide nutrition counseling and food coupons to low income pregnant women and families with young children.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Improve inter-agency collaboration to build the infrastructure needed to support and sustain the Coordinated School Health Program.				X
2. Collects nutrition and weight data for pre-adolescent school children.				X
3. Collects weight data on WIC low income children as part of national nutrition surveillance system.				X
4. Provides nutrition counseling and food coupons to low income families with young children.		X		
5. Supports community based organizations to plan and conduct health promotion activities and projects.				X
6. Assure nutrition and physical activity promotion is integrated into MCH programs.				X
7. Promote improved nutrition efforts through the 5-A-Day Coalition.			X	X
8. Promotes healthy lifestyles through public education campaigns.			X	
9.				
10.				

b. Current Activities

Work continues on a 3-year Coordinated School Health Infrastructure grant from the Centers for Disease Control by improving interagency coordination and capacity building between the DOH, DOE and University of Hawaii.

Other key CSHP activities include: educating DOE administrators about importance of school health for academic achievement and increasing administrative capacity to support implementation of programs at the school complex level (a high school and its feeder schools).

DOE's Food Services staff is partnering with the 5-A-Day Coalition to increase cafeteria staff's nutrition knowledge and to provide nutritious lunches and snacks for students. DOE has formed committees to examine different aspects of school nutrition.

Launched at the 2002 Healthy Schools Summit, State teams have been formed to develop a plan to improve children's health. The Hawaii Action for Healthy Kids Team is focusing on changes in the school environment to improve nutrition and physical activity. The team is led by staff from DOE/DOH and includes other stakeholders.

The Kapiolani Medical Center's (KMC) Child Obesity Task Force, a collaborative of public and private representatives, is finalizing their White Paper on childhood overweight and exploring avenues to implement the recommendations. The Body Mass Index Wheel for children

designed for health care professionals was completed and distributed. The Task Force has been a strong voice in the State Legislature for measures to improve nutrition and increase physical activity.

The State Legislature passed a resolution (SCR7) requesting the development of a statewide strategic plan to promote obesity prevention and healthy lifestyles. The lead on this effort will be the Healthy Hawaii Initiative (HHI) in collaboration with other stakeholders including Title V.

Preliminary data collected between 2000-2004 from the Nutrition Education Needs Assessment Survey (NENAS), conducted in public schools every ten years, shows an overweight problem among youth and teens (see attachment). Over one-third of Hawaii 4th graders and high schools students are overweight or at-risk of being overweight.

The DOH Community Health Division completed their retrospective study on data from school health forms submitted at kindergarten. Analysis of the 9,804 records shows that Hawaii's 4 and 5 year olds are entering public schools overweight and at-risk for overweight (29% over all) with differences in rates between school complexes reflecting the ethnic and social characteristics of the communities.

As part of the Title V 5-year needs assessment, childhood obesity was identified as a continuing health priority. A problem analysis was begun to identify major risk/protective factors and existing services in conjunction with stakeholders.

Title V is working with the National Adolescent Health Information Center (NAHIC) to analyze weight-related data from a child health survey conducted for a previous Title V Needs Assessment.

c. Plan for the Coming Year

Based on previous year's data, the objectives for this measure were revised upward to create more realistic goals.

Reliable population based data on the weight status of Hawaii's children continues to be a need. Title V staff will continue to focus efforts to find reliable and sustainable population-based data sources to understand the prevalence and the risk factors associated with obesity across the state.

Title V will collaborate with initiatives in schools and communities that propose to collect data on obesity in children. For example, Waianae Coast Comprehensive Health Center, a community health center, and the Kapiolani Medical Center for Women and Children in Honolulu are addressing this problem, convening stakeholders to identify feasible strategies.

The NENAS final report when available, will provide more detailed local data to help target interventions and develop effective programs for children and families.

The Community Health Division (CHD) is the lead agency in DOH for programs addressing chronic disease prevention, including obesity. CHD is currently developing an integrated chronic disease management plan that should be completed sometime in FY 2005.

Title V staff will continue to collaborate with the DOH's Nutrition and Physical Activity programs to assure that a two-pronged approach to weight control, nutrition and activity, be integrated into Title V programs and contracts.

Evaluation results from the HHI "1% or Less" milk campaign showed a 9.45% increase in low-fat milk consumption. Approximately 60,000 adults switched to low-fat milk during the course of

the campaign. The DOH HHI program is planning additional media campaigns to encourage people to perform 30 minutes of physical exercise each day, eat more fruits and vegetables, and reduce their calorie intake.

HHI will also coordinate efforts to develop a strategic plan to promote obesity prevention and healthy lifestyles as mandated by the Legislature. Title V is one of the key stakeholders that will participate along with other DOH programs and community stakeholders.

In addition to supporting classroom instruction, CSHP work will continue to strengthen infrastructure by improving decision-making, communication, expertise and resource support around school health. The goal is to maximize resources to create linkages that make schools a healthier place. The CSHP will continue to host regular meetings of DOE, DOH and University staff to improve coordination.

Results from the Title V five-year needs assessment identified two critical age groups to target for obesity prevention: school-age children and children age 0-5 years. School-age issues are being addressed by the CSHP and the KMC Obesity Task Force. However, further problem analysis and strategies are needed for the population between 0-5 years old and their families. A committee of stakeholders has been formed to address the needs of this population that includes WIC and early childhood providers.

State Performance Measure 14: *The percent of families assessed to be at risk for child maltreatment that enroll in Hawaii Healthy Start home visiting support services.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	5450	76	80	83	85
Annual Indicator	5593	76.1	73.5	69.5	68.2
Numerator		2144	2721	1608	1743
Denominator		2819	3700	2315	2557
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	90	90	90	90

Notes - 2002

This measure was revised and has a new data source: the Hawaii Healthy Start Program. Data prior to FY 2001 reflects the number of calls made to the state toll free Parent Line.

Notes - 2003

This is a new State Performance Measure added in for the five-year report period, FY 2001-

2005.

This measure was revised and has a new data source: the Hawaii Healthy Start Program. Data prior to FY 2001 reflects the number of calls made to the state toll free Parent Line.

Notes - 2004

This measure was revised in FY 2001 using data from the Hawai'i Healthy Start Program. Data prior to FY 2001 reflects the number of calls made to the state toll-free Parent Line. This measure will be dropped next year per findings of the 2005 Title V needs assessment.

a. Last Year's Accomplishments

This measure directly reflects the state MCH priority to assure parenting support and information is made available to all families with children, especially to environmentally at-risk families through Hawaii Healthy Start (HHS), the state's child abuse prevention program. The indicator for FY 2004 is 68.2%. The objective was not met for a third consecutive year. The indicator has been declining since FY2001, 2.6% in FY2002, another 4.1% in FY2003, and finally 1.9% in FY2004. The reason for this slow decline cannot be clearly correlated to any identifiable factors related to program implementation or evidence-based practice.

The HHS program activities are:
- Identify environmentally at-risk families (including risk of child maltreatment and related issues of substance use, family violence, and mental health issues);
- Engage and retain at-risk families in home visiting services;
- Monitor family risk factors to reduce crisis situations; and,
- Strengthen family functioning via reinforcement of positive parenting skills, normal child development (including developmental screening) and linkages to community resources to reduce risk factors and parental stress.

The first program component is a population-based service of universal screening. In FY2004, 2,557 families were positively identified as being environmentally at-risk (13% of births) and 68.2% of these families (approx. 10% of births) voluntarily enrolled in Healthy Start.

The second program component is an enabling service for those eligible families desiring home visits aimed at preventing child abuse and neglect by increasing family functioning, enhancing parent-child interactions, and supporting normal child development to promote safe, healthy, and happy children. On-site program specialists have been instrumental in provision of services, providing expertise in the areas of early identification of potential developmental delays under IDEA, Part C and supporting families with substance use, intimate partner violence, and mental health issues. Forty percent of families enrolled in FY2004 experience current intimate partner abuse and/or substance use. Currently, the program serves a total of 4,776 children in 4,535 at-risk families.

- 95% of enrolled families have an identified medical home;
- 97.9% of children are developmentally age appropriate; and,
- 98% of children enrolled for at least twelve months had no confirmed reports of child abuse/neglect.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Identifies at-risk families.			X	
2. Refer environmentally at-risk families to program services, including		X		

home visiting services from Healthy Start.				
3. Monitor Healthy Start families for potential child abuse, neglect and other health issues.		X		
4. Conduct developmental screens.		X		
5. Refer children with suspected developmental delays for professional evaluation.			X	
6. Provide case management, including resource and referral information, follow-up, and transition.		X		X
7. Connect families to a medical home to assure regular source of medical care.		X		
8. Increase family functioning via positive parent-child interaction.		X		
9. Inform parents about normal child development.		X		
10. Support parents at high-risk from substance abuse, family violence, and mental health issues via consultation, referral, follow-up.		X		X

b. Current Activities

Given recent performance, MCHB has contracted with Johns Hopkins University to conduct research evaluation activities related to engagement and retention as a means of collecting more specific information on barriers and development of related and specific quality improvement strategies.

c. Plan for the Coming Year

This performance measure was used as a proxy for the state priority to assure adequate parenting support since a population based measure could not be identified. The measure has not proven helpful in assessing progress toward achieving the priority. Indeed, it was determined through the current Title V needs assessment that the priority does not represent a well defined community need that is feasible to address. The priority really emerged from a Division goal and programmatic focus (Family & Community Support Services Section) and will continue to function as such. The performance measure and priority will be dropped next year.

State Performance Measure 15: *The degree to which the MCH agency performs ten essential public health functions, as measured on a scale from 0 to 30.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	12	15.8	16.8	17.9	18.9
Annual Indicator	15	14	17	21	21
Numerator	15	14	17	21	21
Denominator	1	1	1	1	1
Is the Data Provisional or				Final	Final

Final?					
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	19.9	20.9	21.9	23	24

Notes - 2002

This is a new State Performance Measure added in for the five-year report period, FY 2001-2005.

The Capacity Assessment for State Title V (CAST-5) assessment and planning tools for state Title V programs is being implemented by the state's MCH program. The terminology used in this measure has been modified to be consistent with those utilized in CAST-5. Consequently the 2000 data cannot be compared to the later data

Notes - 2003

This is a new State Performance Measure added in for the five-year report period, FY 2001-2005.

The Capacity Assessment for State Title V (CAST-5) assessment and planning tools for state Title V programs is being implemented by the state's MCH program. The terminology used in this measure has been modified to be consistent with those utilized in CAST-5. Consequently the 2000 data cannot be compared to the later data

Notes - 2004

The Capacity Assessment for State Title V (CAST-5) assessment and planning tools for state Title V programs is being implemented by the state’s MCH program. The terminology used in this measure has been modified to be consistent with those utilized in CAST-5. Consequently the 2000 data cannot be compared to the later data. This measure will be dropped next year per findings of the 2005 Title V needs assessment.

a. Last Year's Accomplishments

This measure reflects the State priority to improve assessment and surveillance of MCH populations, including children with special health care needs and is based on a checklist of the ten essential public health services for maternal and child health. The 2004 score for this measure is 21. The objective of 18.9 was met. Data for this measure is a consensus score determined by the MCH agency's core staff composed of senior level management. The checklist is attached.

Training was provided to Title V agency staff in January 2002 on Capacity Assessment for State Title V (CAST-5), which has been adopted as the tool for measuring SPM #15 and for developing strategic direction for capacity building activities. This measure is related to Healthy People 2010 Objective 23-11: (Developmental) Increase the proportion of State and local public health agencies that meet national performance standards for essential public health services.

The Title V staff continues to focus on the ten essential public health services, which have been integrated into more of their work. Although public health capacity has improved, the level of improvement was not sufficient to increase the score. Therefore, the indicator for 2003 and 2004 is 21, which means that the agency is fully adequate in the providing these public health services. The following describes some significant activities that took place in 2004.

The Title V needs assessment process served as the mechanism to carry out several of the essential public health services to promote maternal and child health. Staff improved in capacity to assess health problems, identify priority health issues, collaborate with stakeholders and effectively address MCH needs. Technical assistance provided by CDC Epidemiologist Bill

Sappenfield, M.D., M.P.H. was valuable in providing direction to the overall process and specifically to the problem analysis. The logic model was selected as the tool for carrying out a problem analysis of each of the nine Title V priorities.

Public health workforce capacity has also been enhanced through local and national training and conferences. Staff has attended a series of local data training modules provided by the Hawaii Outcomes Institute, enrolled in the MCH Certificate Program at the University of Hawaii (UH) Department of Public Health Sciences and Epidemiology (DPHSE), and attended the National MCH Leadership Training.

Data from the 2001 National Survey of CSHN were analyzed by the CSHN Branch, the CDC assigned MCH epidemiologist and the UH DPHSE to identify factors that contribute to difficulty accessing community-based services. The results showed major obstacles to care which can direct program and policy change. An article will be published in the MCH Journal.

Analysis of PRAMS data continued, and reports on substance use and unintended pregnancy were completed. The Title V agency and stakeholders are interested using the analysis for program planning and policy development.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Obtain technical assistance and training to improve staff data collection and analysis skills.				X
2. Develop and enhance surveillance systems.				X
3. Obtain technical assistance on collaboration, logic model and assessment of the service system.				X
4. Mobilize partnerships to identify and solve MCH problems.				X
5. Continue ongoing MCH needs assessment in partnership with community stakeholders.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The major activity during the current year has been the Title V needs assessment. As compared to the needs assessment submitted five years ago, staff is more fully engaged and is realizing the ongoing nature of this work. The Title V agency expects that the needs assessment process will continue for the next five years. Although staff capacity and competency has improved, additional needs for technical assistance have become apparent. These needs are included in Form 15, Technical Assistance Request: 1) strategies and principles of collaboration with multiple and varied stakeholders; 2) logic model; 3) assessment and analysis of the service system.

Enhancing data capacity has been a focus of the Title V agency. The Research and Advisory Committee (RAC) composed of Title V staff continues to address data capacity concerns and promote skill-building activities. The RAC completed a 2005 Title V database inventory that will

be an excellent resource for staff. The Hawaii Outcomes Institute has continued to provide general data related training as well as specific training on using the Hawaii Health Data Warehouse. The Warehouse is now completed and will continue to add new databases. SSDI activities have focused on data linkage in collaboration with the Office of Health Status Monitoring, CSHNB, WIC and Medicaid. Please see the narrative on HSCI #9 for details.

The PRAMS database continues to be analyzed and perinatal issues such as prematurity are being investigated. The Hawaii Breastfeeding Prevalence Study, which is a follow-up study based on a sample of respondents to PRAMS, is continuing. This study will examine ethnic and geographic disparities in breastfeeding initiation, exclusivity and duration rates

Through a memorandum of agreement with the Department of Human Services (DHS), the Title V agency was able to establish a mechanism for linking children in the Child Welfare Services system to Hawaii's Healthy Start home visiting program. Beginning July 1, 2005 an additional $3.2 million from the DHS Temporary Assistance to Needy Families (TANF) program will be used to expand this Title V administered home visiting program.

The CSHN Branch recently received funding for a three year Hilopa`a project to assure access to comprehensive, quality systems of care by linking families to needed services. Project activities include development of a transition program, training families on navigating the service system, and enhancing opportunities for family support and training.

The strength of the Title V agency is its ability to mobilize partnerships to identify and solve MCH problems. Leadership in this area has been demonstrated in the Title V needs assessment, planning the early childhood comprehensive system, and further enhancement of the child death review program.

c. Plan for the Coming Year

As part of the Title V MCH needs assessment, an evaluation was conducted of existing priority needs. Since the focus on essential public health services has become an integral part of the Title V agency's work and is supported by the Department of Health, the Title V Needs Assessment Steering Committee agreed to delete this as a priority for the Title V needs assessment. Because of the importance of essential public health services, the Title V agency will continue to use this checklist to monitor its progress at least annually.

State Performance Measure 16: *Percent of children 0-3 who are developmentally delayed or biologically/environmentally at risk who receive early intervention services to meet needs specified in their Individual Family Support Plan.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	100	100	100	100	100
Annual Indicator	99.7	100.0	100.0	100.0	100.0
Numerator	3562	3956	4999	4178	3936

Denominator	3572	3956	4999	4178	3936
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	

Notes - 2003

This is a new State Performance Measure added in for the five-year report period, FY 2001-2005.

Notes - 2004

This data is the Hawaii Early Intervention Services program.

a. Last Year's Accomplishments

The 2004 federal child count identified 3,936 eligible children who received Early Intervention (EI) services, or 7.3% of all children ages 0-3. Children with developmental delays/biological risk equaled 4.4%. Hawaii serves a higher percentage of children than the majority of states.

Early Intervention Section (EIS) is the lead agency responsible for the statewide system of early intervention (EI) services for infants/toddlers 0-3 years who are developmentally delayed or biologically/environmentally at risk. Services are mandated by Part C of Individuals with Disabilities Education Act (IDEA), Hawaii Statutes SS321-352, and the Felix Consent Decree.

EI services include: assistive technology, audiology, family training, counseling, home visiting, health services, medical services (diagnostic/evaluation), nursing, occupational therapy, physical therapy, psychological, social work, special instruction, speech pathology, transportation, vision services. EI services are typically provided in natural environments by EIS, Healthy Start (HS), and Public Health Nursing Branch (PHNB), and through state and contracted programs, fee-for-service providers, and other programs such as Early Head Start.

EIS is responsible for developing, maintaining, and improving components of the statewide EI system, including: a central directory of service providers, public awareness, child find, evaluation/assessment, Individual Family Support Plan (IFSP), personnel standards, procedural safeguards, complaint resolution, interagency agreements, and data collection.

All eligible children received EI services. Factors contributing to temporary service gaps included staff vacancies, recruiting difficulties, increased travel time to serve children in natural environments, insufficient number of providers. Gaps were addressed by using fee-for-service providers and a transdisciplinary service approach. To increase resources, EIS requested additional funds for contracted agencies to hire staff, and position upgrades to attract qualified/experienced state applicants.

Medicaid/QUEST reimbursement is through a Memorandum of Agreement with the Dept. of Human Services. DHS also supports two other EIS programs: the Inclusion Project provides tuition support for infants/toddlers with developmental delays to participate in community preschools/childcare; the Keiki Care Project provides technical assistance/training to preschool staff serving children 3-5 with behavioral challenges and their families. EIS is funded by the DOH/Child and Adolescent Mental Health Division (CAMHD) to support the COACH Project that provides technical assistance/training to preschool staff serving children with behavioral challenges who are not DOE eligible. The State Improvement Grant (SIG), funded by Dept. of Education supported training activities. The Hawaii Early Childhood Hearing Detection and Intervention Project supported services to infants/toddlers with hearing loss and their families.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide general 0-3 information and central point of contact and link to early intervention services (H-KISS hotline).	X	X	X	X
2. Provide/contract for early intervention services for children 0-3 years with developmental delays or biologically/environmentally at risk.	X	X		X
3. Provide training and support for families and service providers of children 0-5 years old with delays or biologically/ environmentally at risk, including challenging behavior.		X		X
4. Provide respite services for children with developmental delay (0-3 years) or serious/chronic illness (0-20 years)		X		X
5. Increase public awareness including brochures, newsletters, and information at community events.			X	X
6. Provide and/or support training on IDEA Part C, State Plan, IFSP, transition, inclusion, infant mental health, CDEs using the HELP, etc.				X
7. Assure quality of service provision through internal quality assurance plan, program monitoring, internal service testing, family surveys, and evaluation of child/family progress.				X
8. Implement Office of Special Education Programs (OSEP) approved improvement plan to be in compliance with Part C of IDEA, complete State Performance Plan and Annual Performance Report.				X
9. Monitor and evaluate resources and needs through tracking services, staffing, funding/expenses, etc.				X
10. Assess and assure early intervention services meet the increased number of children and service needs.				X

b. Current Activities

EI services continue to be provided under Part C of IDEA. The projects identified above continue. The focus of the SIG has changed from training to early identification and transition from EI to DOE.

The focus of training has been on IDEA Part C requirements as a result of federal monitoring. EIS has met its initial goal of ensuring that all EI staff (EIS, PHNB, HS) attends a 3-day training on federal regulations, IFSP development and transition that was developed by EIS. As a result of developing a statewide IFSP, there has been statewide training on the implementation of this form. EIS continues to support staff and families to attend other trainings and conferences (e.g. the Pac Rim conference for people with disabilities, their families, researchers and professionals, SPIN-Special Parent Information Network- conference, and Early Childhood Conference). Childcare reimbursement is provided to support family attendance.

Public awareness activities include participation in health fairs and other community activities, brochures, newsletters, and information to pediatricians/family practitioners. Information is included in hospitals' birth packets. EIS is identifying underserved populations.

To continue Medicaid reimbursement for EI services, EIS is developing appropriate policies and procedures necessary to meet Balanced Budget Act requirements.

EIS submitted its Annual Performance Plan (APR) to the federal Office of Special Education

Programs (OSEP) on the State's progress in developing a system to address areas of non-compliance with Part C/IDEA. Data was provided from statewide monitoring of EIS, PHNB, HS state and contracted programs in: evaluation in all 5 developmental areas, developing IFSP with all required content, and transition planning/implementation. State staff monitored the Part C programs and identified areas of need, which are now being addressed through programs' Improvement Plans. Data was provided on the results of the internal reviews, which identify child and system progress, and state surveys. EIS Quality Assurance (QA) staff support the improvement of programs.

EIS' goal is to have each child/family served by an EI program. To support this goal and the increased numbers of children with developmental delays, three new contracted EIS programs on Oahu started. To support the need for multi-disciplinary comprehensive developmental evaluations, agencies were contracted.

EIS developed consent forms to support Family Educational Rights and Privacy Act (FERPA) requirements and Billing.

EIS is identifying necessary changes to its State Plan and State Statues due to the reauthorization of IDEA 2004, and is developing a 6-year OSEP-required State Performance Plan.

c. Plan for the Coming Year

Mandated EI services will continue to be provided under Part C of IDEA for infants and toddlers age 0-3 years who are developmentally delayed, biologically at risk, or environmentally at risk.

EIS will continue developing, maintaining, and improving components of the statewide EI system. Some aspects of the system will change based on the new requirements of IDEA 2004, including identifying serving children at confirmed child abuse and neglect and homeless children. EIS will continue to work toward 100% compliance with IDEA Part C requirements, especially in the area of comprehensive developmental evaluations (CDE) for all children, meeting federal timelines, having complete IFSPs, providing all services on IFSPs, developing appropriate transition plans, and ensuring timely transition to DOE preschool special education or community programs. EIS will expand monitoring of all EI public and private programs to identify and correct areas of noncompliance. QA staff will continue to support program improvement; internal reviews will identify child development and system performance strengths and needs. EIS is working collaboratively with UH Center on Disabilities on a new grant to determine child and family progress, a new focus of OSEP.

EI state and contracted programs will expand to serve the increased number of children with developmental delays. EIS will address resource issues by monitoring and tracking the number of children served and the cost of serving all children at EI programs. EIS will also determine the impact financially and resource-wise of expanding the numbers of children served through the addition of children with confirmed child abuse and neglect as well as homeless children/families. DOH will determine if an emergency budget is needed to meet the increased cost of EIS.

EIS will continue to provide and/or support training. The focus will be on transition, IFSP training, and increasing staff expertise (e.g., social worker, PHN) using the Hawaii Early Learning Profile for the CDE so that all children will receive a CDE. Collaborative training with DOE will continue.

Public awareness activities will continue, with a focus on meeting expanded IDEA 2004 requirements. H-KISS, hotline for general 0-3 information and central point of contact & link to EI services, will expand as all children discharged from Kapiolani Medical Center's Neonatal

Intensive Care Unit (NICU) Center and all children at confirmed child abuse and neglect will be referred to H-KISS for connection with service coordination and EI services.

EIS will continue its collaborative activities with DHS, DOE, and DOH/CAMHD and will identify new agencies with which to work.

EIS will revise its Early Intervention State Plan and hold public hearings, and develop the 6-year State Performance Plan collaboratively with families and providers.

EIS will also expand the membership of the Hawaii Early Intervention Coordinating Council to meet IDEA 2004 requirements.

E. OTHER PROGRAM ACTIVITIES

PRESCHOOL DEVELOPMENTAL SCREENING PROGRAM (PDSP) is a statewide program that promotes early identification and intervention of developmental, learning, behavioral, and social-emotional problems for children age 3 to kindergarten entry. PDSP trains community resources, including early education/care providers, in standardized screening. PDSP provides consultation and facilitates follow-up, including evaluation, providing intervention strategies for families and early education/care providers, referral to the Department of Education for special education, referral to other community resources, and monitoring.

THE GENETICS PROGRAM develops statewide genetics activities in coordination with other public/private organizations; assesses genetic needs and develops policies and programs to meet the needs; promotes the prevention, detection, and treatment of genetic disorders; and provides genetics education for the professional and lay communities. The "Western States Genetic Services Collaborative" is a multi-state grant funded by the MCH Bureau to develop and pilot a regional practice model that improves access to specialty genetic services, comprehensive primary care, and care coordination for Hawaii, Idaho, and Oregon children with heritable disorders; and to increase the capacity of Alaska, California, Hawaii, Idaho, Nevada, Oregon, Washington, and Guam genetics and newborn screening programs to perform their assessment, policy development, and assurance functions. "Hawaii Sickle Cell Disease Project", funded by the MCH Bureau, will develop sickle cell disease and trait clinical services, education, materials, and training opportunities for health professionals and public health staff.

HAWAII BIRTH DEFECTS PROGRAM (HBDP) is a population-based active surveillance system for birth defects and other adverse pregnancy outcomes. Since 1988, it has been an accurate, complete, and timely source of statewide data on infants with specific birth defects, and pregnancies resulting in adverse reproductive outcomes. It annually finds and collects demographic, diagnostic, and health risk information on 800 to 1,000 infants diagnosed with a birth defect. Data are analyzed for incidence, trends, and clustering, which contribute to the identification of genetic, environmental hazards, and other causes or risk factors. HBDP is now funded from $10 of each marriage license fee which goes into a special fund, and established as a program in the DOH as a result of a law passed by the 2002 State Legislature (H.R.S. SS321-421).

HEALTHY CHILD CARE HAWAII (HCCH) is a collaborative project of FHSD/CSHNB, University of Hawaii Department of Pediatrics, American Academy of Pediatrics-Hawaii Chapter, and Department of Human Services. HCCH promotes the health and safety of young children in child care, based on the national health and safety performance standards in child care settings. HCCH recruits, trains, and connects health consultants to child care programs; trains pediatric residents in providing presentations on health topics for families and staff at child care sites; provides education/information at conferences; and other activities. HCCH was previously funded by the MCH Bureau. DHS began providing funding in June 2002, and is now providing the only funding support for HCCH for FY2006.

CSHNB provides in-kind support.

SAFE SLEEP HAWAII's goal is to reduce the numbers of deaths through an awareness campaign targeting parents, caregivers, and health care providers. This will be done through: existing programs serving young families, a public awareness campaign, and hospitals with birthing facilities. The committee has begun an outreach campaign using informational packets, PSA's, and educational sessions. Many agencies that service young families are represented on the Committee which functions as a sub-committee of the Keiki Injury Prevention Coalition.

THE PARENT LINE is a free, statewide telephone warm line that provides support, encouragement, informal counseling, information, and referral to callers experiencing concerns about their child's development and behavior or who have issues regarding family stresses or questions on community resources. The Parent Line Office also publishes and distributes: Keiki ‘O Hawaii which is an early childhood developmental newsletter distributed in the hospitals to first-time parents, the Teddy Bear Post parent education newsletters, distributed to families of preschool age children, the Keiki ‘O Hawaii Parent Resource Directory which gives parents information on accessing services and is distributed to parents of young children and to agencies helping them, and the A Happy Start brochure distributed to parents of children who are preparing to enter kindergarten.

PARENTING SUPPORT PROGRAMS include: HomeReach- short-term home visitation services to resolve a parenting concern or family crisis, Mobile Outreach- activities and programs to isolated or homeless families that promote age-appropriate parent-child interaction, communication, and positive discipline, Community-based Parent Support Groups (via The Baby Hui)- parenting and appropriate child development/guidance support though volunteer led peer parent groups, Respite Services- care giving relief, parent education and support on Oahu to high risk families having crises or difficulties with parenting and family stress, Services for Children who have Witnessed Violence (via The Family Peace Center)- intended to help children cope with their emotional responses to violence and by helping the family create a safe, stable, and nurturing environment for the child by teaching parents to have age-appropriate expectations and an awareness of the effects of violence on children.

F. TECHNICAL ASSISTANCE

See Form 15 for Technical Assistance request.

V. BUDGET NARRATIVE

A. EXPENDITURES

Significant Budget Variations -- Form 3 (Fiscal Year 2004)

The total Title V Block Grant amount awarded to the State in fiscal year 2004 was $2,484,701. Out of this total grant award, a sum of only $684,824 was expended in federal fiscal year 2004 due to carryovers from fiscal year 2003. Actual expenditures for the category "Unobligated Balance" ($1,706,605) was higher than the budgeted amount of $1,196,537 used for the FY 2004 Title V application. (The unobligated balance was underestimated for the FY 2004 Title V application.) The actual expenditures for the category "Program Income" was $1,443,778 less than the budgeted amount because of a significant backlog in reimbursements from Medicaid for the Healthy Start and Early Intervention Programs. Actual expenditures for the category "Other Federal Funds" was $6,842,079 less than the budgeted amount of $42,763,132 primarily due to a segregation in accounting of the infant formula manufacturer's rebates under WIC. The rebates will no longer be included as part of the WIC grant commencing with the FY 2006 Title V grant application.

Significant Budget Variations -- Form 4 (Fiscal Year 2004)

In fiscal year 2004, the State's expenditures for the category "Children with Special Healthcare Needs" was $1,661,346 less than what was budgeted for because of a significant backlog in reimbursements from Medicaid for the Healthy Start and Early Intervention Programs. In fiscal year 2004, the State's expenditures for the category "Administration" was $281,271 more than what was budgeted for because three neighbor island District Health Office nurse positions and clerical staff were not included in the fiscal year 2004 budget.

Significant Budget Variations -- Form 5 (Fiscal Year 2004)

The State expended $1,885,989 less than budgeted for under the category "Enabling Services" primarily due to reduced spending by the Healthy Start Program and a significant backlog in reimbursements from Medicaid for the Healthy Start and Early Intervention Programs to pay for services under this category.

Expended amounts for the category "Infrastructure Building Services" was $825,057 less than what was budgeted for in fiscal year 2004. As a whole, the State's expenditures were less than what was budgeted for in fiscal year 2004 and this is reflective of the amounts expended for "Infrastructure Building Services."

B. BUDGET

The State's maintenance of effort level from 1989 is $11,910,549 and the State's overmatch in fiscal year 2006 is $30,715,145. There is no continuation funding for special projects or special consolidated projects in fiscal year 2006.

Significant Budget Variations -- Form 3 (Fiscal Year 2006)

The "Federal Allocation" category for fiscal year 2006 amounts to $2,381,011. This figure is based on last year's grant award.

The category "Unobligated Balance" is estimated to be $1,090,055. This estimated balance from the fiscal year 2005 grant will be used to fund positions within the Family Health Services Division which provide infrastructure building related services. The Family Health Services Division has approximately fifty Title V Block Grant funded positions. Historically speaking, the Division has had a substantial amount of unobligated funds which got carried over from one fiscal year into the next. This conservative approach was taken to ensure that there would be adequate funds to cover payroll costs

for new positions and to fund annual increases in the fringe benefit and collective bargaining rates for existing employees.

There has been an increase of $3,250,365 in the category "State Funds" from fiscal year 2005 to fiscal year 2006 primarily due to an appropriation of $1,700,000 for primary care services to the uninsured and an appropriation of $1,000,000 for grants to rural hospitals. There has been a $7,669,698 decrease in the "Other Funds" category from fiscal year 2005 to fiscal year 2006 primarily due to an approximate $5,200,000 reduction in the Tobacco Settlement Funds for the Health Start Program. The budget for the category "Program Income" has increased by $1,568,567 due to projected increases in Medicaid reimbursements for the Early Intervention and Healthy Start Programs. There is a reduction of approximately $4,108,007 in the "Other Federal Funds category" from fiscal year 2005 to fiscal year 2006 primarily due to the segregation in accounting of the infant formula manufacturer's rebates under WIC. There also have been a number of federal grants which have terminated as of fiscal year 2005.

Significant Budget Variations -- Form 4 (Fiscal Year 2006)

There was an increase of $734,491 increase from fiscal year 2005 to fiscal year 2006 in the category "Pregnant Women." The reason for this increase is due to the inclusion of a portion of the Domestic Violence Prevention and Sexual Assault Programs into this category. There is a proportionate budget decrease of $3,244,691 in the category "Infants < 1 year old" from fiscal year 2005 to fiscal year 2006 primarily due to the reduction of Tobacco Settlement Funds for the Healthy Start Program. Likewise, there is a proportionate budget decrease of $2,582,438 in the category "Children 1 to 22 years old" primarily due to the reduction of Tobacco Settlement Funds for the Healthy Start Program. The budget category "Children with Special Healthcare Needs" was increased by $1,878,896 from fiscal year 2005 to fiscal year 2006 primarily due to projected increases in Medicaid reimbursements for the Early Intervention Program. An increase of $210,525 under the category "Administration" from fiscal year 2005 to fiscal year 2006 is due to projected collective bargaining and fringe benefit increases.

Significant Budget Variations -- Form 5 (Fiscal Year 2006)

There is a decrease of $3,170,730 for the category "Enabling Services" from fiscal year 2005 to fiscal year 2006 which is due primarily to a $5,200,000 reduction in Tobacco Settlement funds for the Healthy Start Program. (Approximately 60% of the Tobacco Settlement funds for the Healthy Start Program was targeted towards Enabling Services in last fiscal year's grant application.)

Finally, the category "Infrastructure Building Services" reflects a decrease of $1,188,814 from fiscal year 2005 to fiscal year 2006. The reasons for this decrease include: 1) a reduction in infrastructure building services for the Healthy Start Program from 10% in last fiscal year's grant application to 5% in this fiscal year's grant application due to position vacancies; 2) deletion of infrastructure building services for the School Based Initiative Program which was transferred to another staff office within the Department of Health; and 3) a reduction in funds for the Child Death Review Program which is classified entirely under the infrastructure building services category.

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting Documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.